dislocation gradually progresses Hitchcock was unable to find in the literature a single case in which progression of the spondylolisthesis from one examination to the next had been demonstrated roentgenographically. He reported three cases of his own with roentgenographic evidence of progressive slipping of the fifth lumbar vertebra on the sacrum; trauma of delivery was held responsible.

Backache from Senile Osteoporosis. Black[51] studied 208 cases of this condition.

> The sex incidence was four females to one male (167 to 41). The average age of patients was 62 (minimum 45, maximum 87) years when diagnosis was first made. Usual symptoms were weakness, fatigue, a dull ache over the lower back for about three years (average), then as a result of slight trauma the onset of more acute pain, at times severe enough to confine the patient to bed. Pain is relieved by rest and supports, aggravated by activity, twisting, and lifting. This clinical picture is characteristic but not diagnostic. Blood calcium, phosphorus and phosphatase are normal, but roentgenograms are characteristic. Age cannot be the only causative factor since most old persons are not so affected. Treatment aims to replenish calcium and phosphorus in bones; it involves use of a diet rich in calcium and phosphorus, supplemented by calcium phosphate and vitamin D (e.g., tribasic calcium phosphate 1 drachm [4.0 gm.]) and cod-liver oil (1 fluidrachm or 4 c.c.) three times a day before meals; also mild sedatives, heat, massage and support for the back (high backed corset). Despite prolonged treatment roentgenograms showed no recalcification but pain and progressive kyphotic deformity were relieved as shown by the fact that symptoms often returned when treatment was stopped.
>
> [Albright and his colleagues[11] have stated that many cases of postmenopausal senile osteoporosis are probably due to loss of estrin. Estrogenic therapy will produce a positive calcium balance.—Ed.]

Postmortem studies on senile kyphosis indicate that the essential pathologic process is pressure necrosis of the anterior portion of the intervertebral disk (Saunders and Inman). The abnormal pressure on the anterior portion of the disk, leading to its necrosis, results from general loss of muscular tone in the aged and the failure of the senile inelastic disk to disperse adequately the compression forces applied to it. The vertebral bodies do not become notably wedge shaped, since the anterior narrowing of disks is sufficient to account for the deformiy.

Backache and Sciatica from "Hypertrophied" Ligamenta Flava. English reports thereon have been scarce; one appeared (Dickson and Twort).

Backache from Spinal Malignancy. Seven patients were referred to Campbell[91] presumably with "rheumatism." In each case the back or leg pains were due to carcinomatosis of bone. Chief diagnostic criteria were the type of pain, anemia and (sometimes) the roentgenographic changes present. Pain was severe, unrelieved by usual antirheumatic remedies, deep seated, gnawing and usually unrelated to movement; eventually it became more intense and continuous. There was a hypochromic anemia or a myelogenous (leuko-erythroblastic) anemia—a moderately high color index and the presence of abnormal red and white cells, reflecting stimulation of bone marrow. Erythrocyte counts were usually between 3,500,000 and

4,000,000, sometimes lower. Roentgenographic changes were sometimes long delayed.

[Of supplementary value to the above is the axiom of one of us, P. S. H.: In cases of rheumatism requiring narcotics, suspect malignancy."—Ed.]

Backache from Spinal Actinomycosis. A case was reported.[292]

Backache and Sciatica from Diseases of Intervertebral Disks

An extensive review of the anatomy, physiology and pathology of intervertebral disks appeared (Saunders and Inman). The commonly recognized lesions of disks are senile fragmentation (without protrusion of disk material) and ruptured disks. A third and little known condition also affects disks—lesions due to acute infections.

Acute Infectious Lesions of Intervertebral Disks. This lesion of the spinal column, involving chiefly the disks, with a more or less severe febrile onset, resulting probably from a primary or secondary infectious process was described by Ghormley, Bickel and Dickson. It has erroneously been called "vertebral osteomyelitis," but involvement of vertebrae is negligible; hence the condition should be considered a separate entity. It is a condition seen in some cases of "typhoid spine" and in spinal brucellosis. Twenty cases were described. Eventual thinning of the affected intervertebral space and later proliferation of new bone along vertebral margins occur. Prognosis is excellent. Treatment is by conservative orthopedic measures.

Ruptured Intervertebral Disks. From the great number of papers appearing thereon it might be assumed that this condition is very common, perhaps the commonest cause of backache and sciatica. It was emphasized that such is not the case; the condition is fairly common but such cases still make up only a small percentage of cases of back pain and sciatica (Keegan and Finlayson). Many new American and one English series (Pennybacker) were reported.

1. Cervical Region. Cervical disks are rarely affected. Stookey outlined symptoms of ruptured cervical disks. Presenting symptoms may be pain or stiffness in neck, shoulder girdle, arm, forearm or hand depending on the segment affected. There is gradual weakness and muscular hypotonia, atrophy and fibrillation—symptoms of nerve root pressure. Roentgenograms (ordinary technic) may reveal a narrowed intervertebral space, but such a finding is so common without herniation of disk material that it is of no significance unless associated with positive neurologic findings. Cervical myelograms cannot be made with lipiodol; for diagnosis a combined encephalogram and myelogram must be done with air. Stookey's results with hemilaminectomy were satisfactory.

2. Lumbar Region. More than 90 per cent of protrusions of disk that cause symptoms occur in the last two disks, between fourth and fifth lumbar vertebrae and the lumbosacral disk.[413] Lumbar protrusions occurred in 96

per cent of 500 cases in which operations were performed by Love and Walsh. Among the many characteristic new cases reported, one case was unusual for several reasons. A lesion, thought to be a spinal cord tumor because of neurologic findings and complete spinal block revealed by spinogram, proved at operation to be a calcified protruded disk between the tenth and eleventh thoracic vertebrae (Cohen).[121]

A history of specific trauma was noted in 63 per cent of Johnson's 40 cases, in 58 per cent of the 500 cases of Love and Walsh. Special trauma was a feature of the case of a 14 year old girl reported by Gellman. It consisted of localized injury to intervertebral disks from several unsuccessful spinal taps. Successive roentgenograms revealed the resultant changes Severe lumbar pain and hyperextension developed and later lumbar flexion and prominence of the spinous processes of the second and fourth lumbar vertebrae.

Statistics of the new series resembled those formerly reported. Sex incidence was 358 males to 142 females in one series,[371] 24 males to one female in another series.[609] Sciatica was unilateral in 78 per cent, bilateral in 16 per cent, absent in 6 per cent of 500 cases studied.[371] Sciatica affected all the patients in one series[609] but in one proved case "terrific lumbar backache" without sciatica was present (Baker and Soniat). Achilles reflexes were abnormal in 50, 60[307, 371] and 70[413] per cent of cases. Lasègue's sign was positive in 84 per cent.[371] Motor changes affected 25[371] and 28[307] per cent; sensory loss affected 21 per cent, sphincter loss, 4 per cent.[371] Symptoms were intermittent in 84 per cent of 500 cases,[371] in 96 per cent of 25 cases.[609]

"The one outstanding symptom in these cases is pain, not a mild sciatic pain, but a severe intractable disabling pain which may have long remissions. The one outstanding sign on physical examination is interference with straight leg raising" (Mixter and Barr). Spinal fluid proteins were less than 40 mg. per 100 c.c. in 30 and 40 per cent of cases[81, 371]; they were more than 40 mg. per 100 c.c. in 65 per cent of cases.[296] They are rarely more than 100 mg. per 100 c.c. but they were enormously increased (to 3500 mg. per 100 c.c.) in Bunt's case which simulated tumor of the cauda equina (complete spinal subarachnoid block, yellow spinal fluid).

Technic of myelography was described.[88, 89, 238, 475, 534] Since in most cases back pain and sciatica clear up spontaneously or under conservative measures, myelograms should not be made "unless sciatica has been present months, not weeks" (Mixter and Barr). Robinson[475] considered injections of lipiodol indicated only in cases in which spinal fluid protein is elevated, an adequate trial of orthopedic remedies has failed, some other definite explanation for the sciatica cannot be found, and sacro-iliac or lumbar fusion is contemplated. The use of lipiodol rather than air was preferred by many.[88, 238, 296, 413, 475] Five cubic centimeters were used by some,[88, 238] but Bell[38] considered 2 c.c. adequate and devoid of reactions. The technic involves a total diagnostic error of 11 per cent (Camp and Addington), but false negatives may occur (Mixter and Barr). The occasional reactions and dangers of lipiodol spinograms were noted.[238, 413, 475]

Because of the irritating properties of lipiodol, myelography with air was preferred by some and considered reliable.[44, 104] The accuracy of air myelography varies considerably in the hands of different workers; according to Hampton present methods

carry an error of 50 per cent, hence it is "unsatisfactory" (Johnson). Perfecting their clinical examination, Spurling and Grantham found it unnecessary to do either air or lipiodol myelograms in 50 per cent of their cases. They regarded as "of extreme importance in the diagnosis of intraspinal lesions" the test of Naffziger and Jones (1935), performed by occluding both jugular veins until a sense of fullness in the head affects the patient and until his face is flushed. "If the back pain or paresthesias in legs are reproduced by this maneuver, we consider the finding pathognomonic of intraspinal disease."

Treatment. Before advising operation conservative measures should be tried: rest in bed or use of plaster jacket or some other apparatus to hold the lumbar portion of the spinal column in flexion. This may succeed,[307, 413] but Mixter and Barr considered surgical removal more successful. Instead of the classical laminectomy, surgeons are now using hemilaminectomy [296, 307, 370, 371] or are even removing the disk material interlaminally, without removing any bone.[235, 389, 871] Fusion or bone grafting is rarely necessary even when laminectomy is done [296, 307]; fusion was done in only 15 of 500 surgical cases (Love and Walsh).

Results of treatment continue to be satisfactory. Patients were cured in from 47 [413] to 83 [296] per cent of cases, "cured or markedly relieved" in 76 [307] to 85 [533, 534] per cent. There were two deaths in 123 cases in one series,[413] two deaths in 500 cases in another series [371] (mortality 0.4 per cent). Recurrences were noted in 11,[371] 31,[533] and 4 per cent.[296]

Rheumatoid (Ankylosing) Spondylitis

The most important spinal joints, the apophyseal or posterior intervertebral joints, receive little attention from either roentgenologists, orthopedic surgeons or rheumatologists. These apophyseal joints are true diarthrodial joints—they differ from the synchondroses formed by the disks and vertebral bodies almost as much as the hip joints differ from the pubic symphysis (Oppenheimer).[433] Goldthwait noted that there are 44 true rib joints: 12 costovertebral joints on each side where ribs join the vertebrae and 10 on each side of these where ribs touch the tips of the transverse processes. These joints are seldom studied and are of great importance in ankylosing spondylitis.

Etiology. Lux proposed the thesis [on what appears to us to be inadequate evidence—Ed.] that postural changes secondary to hereditary malformation of the epiphyseal ring of the vertebrae produce the most frequent forms of spondylarthritis. No abnormality of sulfur metabolism was noted.[200] Robinson [474] showed that incidence of tuberculin sensitivity was 30 per cent higher in 45 cases of ankylosing spondylitis than in 90 rheumatic control cases (it was low in peripheral rheumatoid arthritis, a point of contrast with ankylosing spondylitis). No explanation was offered. The antifibrinolysin content of plasma was practically always normal.[451]

Clinical Data. In two years at the Lahey Clinic, Hare saw 1,179 cases of arthritis (including 357 of rheumatoid arthritis); of the latter 21 (6 per

cent) were cases of rheumatoid (Marie-Strümpell) spondylitis, in only four of which peripheral joints were involved. He divided the disease into three phases: (1) prespondylitic phase; (2) phase of sacro-iliitis; (3) phase of poker back deformity. Roentgenographic findings in each phase were described. In all cases sedimentation rates were elevated. Edström posed the question, "Is spondylarthritis ankylopoietica an independent disease or a rheumatic syndrome?" After discussing each point of view he presented reports of seven cases, in six of which there was frank evidence of "chronic rheumatic infectious arthritis." In these six cases various mesenchymal organs were attacked by the rheumatic infection, and arthritis, peritendinitis, bursitis, endocarditis, pleuritis, iritis, subcutaneous nodules and changes in skin and nails developed. He concluded that spondylarthritis ankylopoietica is a rheumatic sydrome belonging to the group of "chronic rheumatic infectious arthritis" (i.e., rheumatoid arthritis). But Osgood regarded ankylosing spondylitis as an entity separate from rheumatoid arthritis.

[Evidence is accumulating that ankylosing spondylitis is only one expression of rheumatoid arthritis, but the point will doubtless be raised by proponents of the other viewpoint that many of the cases described by Edström were cases of rheumatoid arthritis with spinal involvement rather than true cases of ankylosing spondylitis. This criticism is perhaps justified in the case of the patient with subcutaneous nodules whose condition was diagnosed as "spondylarthritis ankylopoietica in the prespondylitic stage." The demonstration of subcutaneous nodules in unequivocal examples of ankylosing spondylitis would go far to settle the controversy.—Ed.]

Roentgenograms. Roentgenographic features were carefully reviewed by Forestier and Robert, also by Oppenheimer [433] who has stressed the importance of the apophyseal joints for several years.

Oppenheimer described the appropriate technics for visualizing the joints—90 degree films in the cervical region, nearly 20 degrees in the thoracic region and 45 degrees in the lumbar region. Various developmental variations and anomalies were considered briefly and a detailed description of the changes seen in both rheumatoid and osteo-arthritis was presented. He concluded that both rheumatoid and osteo-arthritis of apophyseal joints are distinct from "so-called arthritis of the spine" which consists essentially of exostoses at edges of vertebral bodies. "The conception of arthritis, pertaining to lesions of diarthrodial joints, does not apply to the disc synchondroses either clinically or anatomically; the reactions at the edges of the vertebral bodies are *osteitic* but not *arthritic*. It is in the apophyseal joints that arthritis of the spine, a spondylarthritis, is localized."

[We agree.—Ed.]

Treatment. Roentgen therapy was recommended by Hare and Kimmel and by Hare. Results were "striking." In the first series of 21 cases relief of pain was complete in 13, partial in three, absent in five. Stiffness was relieved in 16 cases. In the second report on 35 patients treated, 80 per cent were relieved of pain. [These results are considerably better than those obtained by some, but compare well with the good results recently reported by Smyth, Freyberg and colleagues.[522, 523]—Ed.] Contrary to the opinion of some,[6, 7] Tarsy considered chrysotherapy useful in rheumatoid spondylitis [data incom-

plete—Ed.]. But in such cases toxic hematuria from chrysotherapy seems more likely to develop than in rheumatoid arthritis, according to Sherwood: results of gold in ankylosing spondylitis are "rarely good and the hematuria is so frequent that I now use gold rarely in spondylitis and only with a urinary analysis preceding each dose."

[Sherwood used very small doses of gold salts.—Ed.]

Osteo-arthritic (Hypertrophic) Spondylitis

Few articles on spinal osteo-arthritis appeared. A careful anatomic and pathologic study of cervical intervertebral disks of 50 adult human cadavers was made by Horwitz. Exostoses were present in 70 per cent of instances and corresponded closely with the location of lesions in disks. Horwitz briefly discussed differential diagnosis of pains in neck, shoulder and upper extremity.

[Unfortunately in this as in many other such reports no correlation was made between clinical and pathologic findings.—Ed.]

Headache from arthritis of the cervical portion of the spinal column was described by Hartsock:

> Ranking in frequency with ocular and migraine headaches, this type of headache invariably begins in the occiput and spreads upward and forward into the temporal regions as it becomes more severe. Of great diagnostic importance is the tenderness of the cervical muscle attachment to the skull. Headaches are periodical at first, lasting three to four days, coming on early in the morning and having a tendency toward long sieges of constant pain which may become chronic. A relation exists between the headache and exposure to draft, wetting of the hair or anything which causes tenseness of neck muscles. Crepitus frequently accompanies the headache and is audible when the head is turned from side to side. The headache occurs mostly in elderly (osteo-arthritic) persons; roentgen evidence of cervical osteo-arthritis is usually fairly obvious. A history of arthritic pains especially in the low back, knees and shoulders tends to confirm the osteo-arthritic genesis of these occipital headaches. Diagnosis is important; it relieves the patient's mind and obviates long and expensive search for another possible cause. Usual therapeutic measures were advised. Local injections of procaine for spinal osteo-arthritis gave results satisfactory to Lipkin.

Gout and Gouty Arthritis

Physicians are fortunately becoming more "gout-conscious."[131, 217, 258, 259, 388, 572] Those interested in the history of gout will enjoy a new printing of Sydenham's "Treatment of gout and dropsy" and Hormell's fine note on the history of rheumatism and gout.

Incidence. Gouty arthritis made up 2 per cent of all cases seen in the Rackham Arthritis Research Unit,[202] about 5 per cent of arthritic cases seen at the Cleveland Clinic,[324] and about 4 per cent of all cases at the Red Cross Rheumatism Clinic, London.[568]

Factors Governing Incidence. 1. Heredity. Contrary to British experience, few American victims of gout can trace the disease in their an-

cestors. But the hereditary factor is an important one, in some cases at least, as shown by recent studies demonstrating notable symptomless hyperuricemia in a significant percentage of male relatives of gouty patients.[521, 564]

Twenty-seven gouty patients of Talbott had 136 blood relatives, none of whom had symptoms of gout. Concentrations of serum uric acid of 75 per cent of these relatives were normal (less than 6 mg., average 4.6 mg.); of the rest elevated (6.1 to 10.8 mg., average 7.3); 83 per cent of the relatives who had hyperuricemia were males; subsequently three had acute gouty arthritis. Smyth and Freyberg studied 29 immediate relatives of two gouty persons. In one family the father and three sons had proved gout, the fourth sibling (a daughter) had no attacks but had a high normal value for serum uric acid. In the second family the father had gout, two sons had symptomless hyperuricemia (7.9 and 8.4 mg. per cent), another son had a high normal (5.6 mg. per cent) and a daughter a normal, value for serum urates. Thus of the eight males in these two families, five had active gout, two had symptomless hyperuricemia [larval gout?—Ed.], and one had a high normal concentration of serum uric acid; of the four females none had active gout, two may or may not have had larval gout (high normal values for uric acid) and two had average normal urate concentrations.

[These interesting studies confirm that of Jacobsen.[6]]

2. Sex. The studies just mentioned indicate again that females, even in gouty families, are much less liable than males to have active gout. Of the new cases of gout only 3.5 to 7.4 per cent were in females (three of 62 cases[324]; three of 85[181]; two of 27[564]). Claiborne reported an interesting case of a 17 year old girl with pretophaceous gout of three years' duration.

3. Age. The average age of Kinell and Haden's patients was 50 years; their symptoms had lasted an average of seven years; in 60 per cent their first attacks occurred between the ages of 33 and 50 years. Coomb's patients were from six to 72 years old at the time of initial attacks.

[Cases of provable gout in young children are very rare.—Ed.]

Clinical Data. Patients with gout, currently reported, exhibited the classical features of gout, despite which a correct diagnosis had often been long deferred. The first joint affected in the Cleveland cases[324] was the "first toe joint" in 53 per cent, a "foot" in 17 per cent: thus in 47 per cent the first toe was not affected and in 30 per cent the original attacks did not affect any part of the foot.

1. Provocatives. Among susceptible persons liver extract may provoke acute gouty arthritis. Two such cases were reported. A man with tophaceous gout and congenital hemolytic icterus developed acute gouty arthritis "immediately following a liver injection."[156] A man with pernicious anemia was given, intramuscularly, liver extract on six successive days; a day or two later acute gouty arthritis developed.[434] These attacks were thought to be related to increases of endogenous uric acid accompanying "reticulocyte crises": these increases result from the destruction of erythrocytes in hemolytic jaundice and the augmented nuclear material liberated during blood regeneration when normoblasts lose their nuclei to become normocytes. [One of us, W. B., has been giving every two or three weeks injections of liver extract to two patients with gout and pernicious anemia; the injections do not seem to provoke gouty arthritis.—Ed.] Severe hemorrhages and transfusions have been cited as provocatives: a man with severe anemia as a result of melena for three days, received a transfusion; a few days later acute gouty arthritis developed.[434] Surgical operations may provoke gout: a woman with tophaceous gout and hemolytic icterus developed acute gouty arthritis five days after splenectomy, but her son, with the same complaints, endured splenectomy

without acute postoperative gout.[156] A boy with "erythronoclastic anemia" had an acute attack of gouty arthritis three days after splenectomy.[349]

2. Tophi. In one series of cases tophi were present in 23 per cent.[324] Tophi are uncommon in women and children. Tophaceous gout was seen in three women [434, 564] and in two boys 14 years old with blood dyscrasias.[349, 434] In one case tophi developed before the onset of joint symptoms (Kinell and Haden). Authentic reports of endocardial or valvular tophi are extremely rare; of much interest, therefore, is the case of Bunim and McEwen of a urate tophus of the mitral valve: crystals were removed from the concretion and microscopically identified as urates.

[Unfortunately the gross specimen was fixed in a solution which dissolved urates; hence in the sections, only circumscribed masses of amorphous eosinophilic material were seen. To prevent dissolution of urates suspected tissues should be fixed, not in the usual formalin-containing fixatives, but in absolute alcohol (de Galantha method, 1935). Another intracardiac tophus was seen by one of us (Hench and Darnall, 1933)—Ed.]

3. Renal Stones. In one series 11 per cent of the patients had renal colic (Kinell and Haden), in another 30 per cent (Coombs et al.).[132]

4. Unusual Clinical Features. The association of gout and blood dyscrasias is greater than possible by mere coincidence. Deitrick noted three cases of congenital hemolytic icterus and gout; in one case no gouty attacks occurred for at least seven years after splenectomy. A boy with tophaceous gout (at the age of 14 years) and "chronic erythronoclastic anemia" was studied in great detail by Lambie. The boy was frequently jaundiced but none of his relatives had hemolytic anemia.

[We cannot review adequately this excellent, informative case report. Students of gout are urged to read the original.—Ed.]

Irregular Gout. Three cases of "ocular gout" [331] and one of "gout of the auditory apparatus" simulating Ménière's disease [148] were reported. [We cannot accept the interpretations given. Two of the three patients with "ocular gout" were females; all three had ill defined "rheumatic pains" and slight hyperuricemia; none had classical attacks or tophi. The patient with Ménière's disease had had two attacks of "gouty arthritis" but no attack associated with the vertigo. No tophi were present; no studies of concentration of uric acid were made; no colchicine test was done.—Ed.]

Laboratory Data. 1. Relation of Blood Uric Acid to Gout. There is no "uric acid" in blood; the substance is in the form of sodium biurate; hence we should speak of blood urates.[131, 499] In 82 per cent of the cases of Kinell and Haden a blood level of 3 mg. per cent or more was found (the Morris-MacLeod technic was used by which 2.5 mg. per cent is considered the upper limit of normal). But patients may have proved tophaceous gout with normal blood urates.[324] There was a general but no absolute correlation between the degree of hyperuricemia and the stage of the disease or attacks in the cases of Kinell and Haden. A similar conclusion was made by Brøchner-Mortensen who published a 40 page monograph on the uric acid content in blood and urine in health and disease.

2. Sedimentation Rate. Rates were elevated in 85 per cent of 62 cases and varied with the clinical activity of the disease.[324]

3. Blood Counts. "The ruddy complexion of the gouty patient" is due to "plethora": of the Cleveland cases erythrocyte counts were more than 4,800,000 in 50 per cent, more than 5,000,000 in 24 per cent.[324]

4. Roentgenograms. "Positive roentgen evidence of gout" was found in only 31 per cent of the Cleveland cases. Such evidence was seen in one case two months after onset of symptoms, but was still absent in certain cases in which symptoms had been present for 25 to 30 years.[324]

5. Renal Function. This was impaired to some degree in 18 of 22 cases studied by Coombs and colleagues.

[These were not run of the mill cases of gout, but a select group of late cases as shown by the fact that of the 22 patients 17 had subcutaneous tophi, 12 had osseous tophi and seven had renal urate stones. Hence the conclusions drawn from this study are applicable only to late progressive gout.—Ed.]

Etiology. Gout is a "disturbance of the solubility of uric salts which in extreme cases involves their crystalization in tissues"; normally "the proteins of blood protect the sodium biurate against agglomeration which would take place in the same concentration in a physiological solution. In gout the protective colloidal property in the tissues is destroyed." Such was the theory of Sedlacek who isolated a "substance" from urine considered by him to be the cause of gout. According to Terray, "Everyone knows that the acute attack . . . is caused by the precipitation into the joint of uric acid crystals."

[As a matter of fact nobody knows this for certain, and many authorities have abandoned this concept of the attacks.—Ed.]

Treatment. There was no dispute as to the value of orthodox treatment for acute attacks (Bauer and Short; Hench). "No benefit has been derived from colchicine except in patients with gout and no patient with proved gout has failed to be greatly benefited by it."[202] "We have never seen colchicine fail to give relief."[31] Enough to give relief should be prescribed even if that amount produces diarrhea. There was no agreement, however, as to what constitutes a "diarrhea-dose" of colchicine: some said 8 to 16 doses,[31] others[202] said 14 to 25 tablets, according to others[131] 8 to 19 (in each report the dose was grain $\frac{1}{120}$ every one to two hours). [In our experience it is about 6 to 18 (in one case, 24) $\frac{1}{100}$ grain tablets given one every one to two hours—Ed.] The value of "interval-treatment" was in dispute; several physicians[110, 258, 259, 388, 572] considered it definitely useful but workers[31, 131] at the Massachusetts General Hospital again disputed this idea. They avoid cinchophen and rely on "a sensible diet" which merely excludes the concentrated purines. Sedlacek treated gouty patients with parenteral injections of his "substance"; nothing daunted, he claimed "all kinds of arthritis show improvement or healing on parenteral application of the substance."

[Difficult to believe!—Ed.]

Studies on Colchicine. Newer studies on the effect of colchicine on the growth of normal and malignant tissue cells have not explained its action in gout. The

toxicity of colchicine may be related to hepatic function. Colchicine given to rats with acute hepatic damage or within five days of partial hepatectomy caused serious, often fatal, reactions. Similar doses were well tolerated when livers had had time to regenerate. Colchicine may or may not be detoxified in the liver but the drug should, perhaps, "be used with caution in treating patients with disease of the liver" (Scheifley and Higgins).

Cinchophen Toxicity. Four cases of cinchophen toxicity were reported; again *none were in gouty patients.* An osteo-arthritic patient took cinchophen, grains 15, daily for six days; urticaria and moderately severe (nonfatal) toxic hepatitis developed. A man with pains in chest and shoulder took cinchophen (amount unknown): fatal toxic hepatitis ensued (Berry). A mother and her son took "guaiacin" capsules, Massengill (guaiacol ester of phenyl-cinchoninic acid) for colds. The mother developed nonfatal toxic hepatitis and a duodenal ulcer "produced possibly by the cinchophen." [If so, it is the first human case on record.—Ed.] The son died of acute yellow atrophy (Mac Bryde).

[We believe that cinchophen should never be given for any type of arthritis except gout, and then only when the gout cannot be controlled adequately by other measures. Some of us do not use it even then.—Ed.]

Further studies on cinchophen ulcers in dogs and in chicks appeared.[152, 425, 557, 107] The excretion of cinchophen in bile was studied.[63]

Uric Acid Problem. Further studies were made with the uricase method for determining the "true uric acid" content of blood.[7, 491] Brøchner-Mortensen's excellent monograph cannot be reviewed adequately here. To him it seemed probable that between 90 and 95 per cent of the uric acid which is filtered through glomeruli is reabsorbed by tubules. High fat diets seemed to increase the amount of resorbed urates to 99 per cent of that filtered. [In other words high fat diets do not prevent glomerular excretion but enhance tubular resorption of urates. But the end result is the same; the urates do not pass into the bladder but reënter circulating blood.—Ed.] Cinchophen and salyrgan depress tubular reabsorption of urates, hence they increase urate clearance of normal and gouty persons unless advanced renal insufficiency is present, according to Coombs and his colleagues. These workers believe that cinchophen damages normally functioning cells of the tubules and prevents reabsorption of urates just as salyrgan damages tubular cells and prevents reabsorption of urates, sodium and chloride. [This is theory, not fact.—Ed.] Colchicine appears to have no effect on the renal excretion of urates.

Psoriatic Arthritis

No reference to psoriatic arthritis was made except a statement by Bauckus and Kwak: "There is universal belief that arthritis may be a part of the psoriatic syndrome."

[Whether psoriatic arthritis is a separate entity or represents rheumatoid arthritis with coincidental psoriasis remains in dispute. Certain features presumably characterize psoriatic arthritis: these are asymmetrical peripheral arthritis with frequent involvement of terminal phalangeal joints of fingers and toes; psoriatic changes in adjacent nails; exacerbations and remissions of the joint manifestations "reasonably synchronous" with those in skin.—Ed.]

Incidence. No new data on the incidence of psoriatic arthritis appeared. Ap-

proximately 200 cases have been reported.[7] Psoriasis constitutes about 4 per cent of all skin affections in America.[343]

Etiology. Various theories were discussed.[356, 379] Lerner found that 42 per cent of 172 patients with psoriasis gave a history of the disease in their immediate families.

Treatment. The treatment of psoriasis remains as controversial as its etiology. The value of local therapeutic agents was discussed.[30, 343] Vitamin D preparations were considered safe but unreliable by Clarke,[111] useless and dangerous by Madden. The latter obtained best results by using a low fat diet, vitamin B_1 (1,000 international units daily) and an exfoliating ointment. Ascorbic acid, estrogenic substance, anterior pituitary extract, adrenal cortical extract, sulfanilamide, and bismuth salicylate were considered of no value but eight of 35 patients treated with liver extract and dilute hydrochloric acid improved.[379]

Hemophilic Arthritis

Clinical, pathologic and roentgenographic aspects of hemophilic arthritis were reviewed (Caffey and Schlesinger). Although articular changes develop prior to adolescence in 89 per cent of cases of hemophilia and hemarthrosis (Thomas, 1936), little attention has been given to accelerated epiphyseal maturation associated with juvenile hemophilic arthritis.

Caffey and Schlesinger studied roentgenographically the joints of five children with recurrent hemophilic hemarthrosis. Accelerated maturation of the epiphyses was present at the knee and elbow in one case, at the elbow in a second; in a third case hypertrophy and fragmentation of the radial capitulum were present; a fourth case showed marked increase in size of the epiphyses of the femur and tibia, and enlargement of patella; a fifth case exhibited coxa plana of the hip joint resembling Perthes' disease. Measurements of the effect of chronic hemarthrosis on diaphyseal growth were not made, but overgrowth of an extremity following hemorrhage into a knee has been reported. Accelerated epiphyseal maturation was explained on the basis of chronic irritation and chronic hyperemia induced by repeated hemorrhage, but attempts to accelerate epiphyseal development experimentally by injecting heparinized blood into joints of growing rabbits were unsuccessful. Newer agents to lower coagulation time of patients with hemophilia were described.[352, 397, 437]

Allergic Arthritis

"The arthritis of serum sickness is the only type of arthritis that can be classified as anaphylactic or allergic in nature" (Bauer and Short). The absence of a single article under the title "allergic arthritis" in the American and English literature of 1940 rings a note of encouragement. The term, like "metabolic arthritis," is falling into disuse.

Metabolic Arthritis

No articles under this title appeared.

Endocrine Arthritis

Thyroid Dysfunction and Chronic Rheumatism. Thyroid dysfunction has been blamed as a causative factor in arthritis.[166] Hoskins maintained

that a "thyroid deficiency type" of osteo-arthritis exists, and that the subsidence of joint symptoms is "often miraculous" when thyroid extract is administered.

[The author seemed overenthusiastic about several forms of therapy. Muscle and joint pains occasionally accompany the thyrotoxic state and are frequent complaints in myxedema, but proof is still lacking that any thyroid abnormality can cause arthritis.—Ed.]

Menopausal Rheumatism. The literature of 1940 contained no new data concerning this controversial subject [166, 216] which was thoroughly discussed in a previous Review.[6]

[Writers do not agree as to what constitutes the clinical or pathologic picture of so-called menopausal rheumatism. The rôle played by the climacteric as a predisposing, contributing or causative factor in any of several forms of arthritis also remains in debate. Most American and Italian [464] rheumatologists are reluctant to accept the term "menopausal arthritis."—Ed.]

Joints and Parathyroid Glands. No known type of arthritis is caused by disease of the parathyroid glands.[464] Skeletal and muscular pains especially in back, legs and arms, subjective stiffness, muscular hypotonicity, weakness and fatigability are often present in cases of hyperparathyroidism.[484] Joint pains occasionally may predominate early in the disease but are not to be confused with arthritis.[60] An interesting, and if confirmed, important new concept of parathyroid function was presented by Helfet. He considered that an accumulation of phosphate in the blood stimulates an increased secretion of parathyroid hormone. He reduced the levels of serum calcium and plasma phosphorus by the oral administration of aluminum acetate which diminishes the absorption of phosphates from intestines. The clinical and roentgenographic improvement with such therapy in cases of generalized osteitis fibrosa cystica due to "secondary hyperparathyroidism" was impressive.

[We have commented elsewhere herein on this report.—Ed.]

Miscellaneous Types of Joint Disease

A "New, Oft-Recurring Disease of Joints." An oft-recurring disease of joints apparently producing no residues was described by Hench.[257]

Outstanding features were multiple afebrile attacks of acute arthritis and periarthritis, sometimes also para-arthritis, with pain, swelling, redness and disability, generally of only one, but sometime of more than one, small or large joint of adults of either sex. Attacks appear suddenly, develop rapidly, generally last only a few hours or days and then disappear completely, only to recur at short or long irregularly spaced intervals. Despite the transitory presence of an acute or subacute inflammatory reaction in joint tissues and a fibrinopurulent exudate in articular cavity in some cases, little or no significant functional, pathologic or roentgenographic residues occurred even after years of disease and scores or even hundreds of attacks. Thirty-four cases were summarized.

[A detailed report will soon appear.—Ed.]

Pharmaceutic Arthralgia. Pains in joints and bones occurred in a few cases in which arsenic, iodobismitol or mapharsen was being given. Such pains may be prevented by liver therapy, according to MacKee and Astrachan.

"Synovitis." An unusual form of transitory synovitis of the hip joint of children was described (Rauch).

Diagnosis was made by exclusion: by ruling out all other forms of hip disease, and by observing the patient for several years to see that the disease was not only benign but transitory; this is a form of "observation hip." A list of 40 conditions resembling transitory synovitis was given. In the 37 cases described, the synovitis lasted for from seven to 60 days; an average period of 32 days was needed for recovery. Conservative treatment was advocated, especially rest in bed. Follow-up physical and roentgen examinations were made at the end of one, six, and 12 months and yearly thereafter for three years.

Tumors of Synovia and Joint Tissue. The general characteristics, classification and differential diagnosis were reviewed by McCurdy.

1. Synovioma. Clinical and pathologic features of synovial tumors were presented and a synovial tumor of the foot was described by Black. It was presumably benign and of bursal origin. The relative rarity of benign tumors of this type was emphasized. The roentgenographic recognition of synovioma was discussed by Lewis[358]: an unusual and striking roentgenographic appearance was observed in four cases.

"Near a joint, and sometimes involving a joint, is seen a rounded, sometimes rather lobulated, sharply defined soft tissue tumor mass. No differential diagnosis may be made on such a mass in itself, but when in the mass is found a scattered and irregular deposit of amorphous *lime*, we have learned that a provisional diagnosis of synovioma is justified." No other condition simulates this. Calcifications in angiomas are orderly and are in the characteristic form of phleboliths. Exostoses and osteochondromas are more extensively calcified and have the orderly pattern of bone throughout, except in their cartilaginous caps where the deposit of lime may be irregular.

2. Synovial Granuloma. Spontaneous hemarthrosis attributable to synovial granuloma was reported (Stack).

3. Chondroma. Fifty-six loose bodies (chondromatoses) were removed from a shoulder joint.[407]

Pulmonary Osteo-Arthropathy. Pulmonary osteo-arthropathy may be the first symptom of an intrathoracic tumor. In two of seven cases reported by Van Hazel symptoms disappeared abruptly following removal of the tumors. In some cases the condition simulated arthritis.

[In discussion it was noted that no single explanation was adequate for the occurrence of club fingers in all the different conditions in which it is found. The condition has never been reproduced experimentally.—Ed.]

Cutis Elastica: Ehlers-Danlos Syndrome. Three typical cases were reported, showing hyperelasticity of skin, over-extensibility of joints and fragility of skin and blood vessels.[117, 421, 514]

Osteochondritis Dissecans. Cases involving unusual locations were reported: two typical cases of a hip,[325] one involved a metatarsal head,[97] and three cases involving respectively the elbow, ankle and metatarsal phalangeal joints.[65] The etiology, pathology, clinical picture, roentgenologic findings, diagnosis and treatment were reviewed.[360]

Changes in Joints from Interrupted Articular Circulation. 1. In Caisson Disease. An interesting paper dealing with the skeletal manifestations of caisson disease was contributed by Coley and Moore.

Attention was called to caisson disease as a possible cause of bone and joint pains which may be discovered later to be due to "silent" areas of aseptic necrosis. Long bones are favored sites for symptoms; 70 per cent of symptoms occur in lower extremities, chiefly knees. German authors described 11 cases, in all of which lesions involving a large joint were present: a hip was affected 12 times, a shoulder once. In all cases, except two the arthritis was monarticular. The pathologic reaction results from nutritional interference either from direct embolism in a main nutrient vessel or from pressure on the vessel wall by bubbles or by both of these means. A deforming osteo-arthritis ensues as a result of absorption, collapse, and formation of new bone in or near the epiphysis. Caisson disease may be recognized in roentgenograms by multiple distribution of infarcts in the medullary bone; changes in cortex are rare. The process may be explained on the basis of vascular insufficiency and nutritional disturbance. Two cases were reported.

Another case of caisson disease was reported (Gordon and Heacock). A tunnel worker fractured both tibiae. He was removed to a hospital too hastily to permit adequate decompression. Roentgenograms revealed gas in synovial sacs of both knees. Later the gas was absorbed and there was no permanent articular injury.

2. From Injuries. Interruption of circulation to joints may result from injury; subsequent changes simulate those which may occur in caisson disease. Phemister has amplified studies noted in our last Review. Fractures bordering on joints in certain locations (especially neck of femur, carpal navicular bone and condyles of humerus) may result in extensive severance of connections and aseptic necrosis of the bone of the articular fragment. There is predisposition to nonunion by displacement and by interference with callus formation from the articular fragment. Articular cartilage undergoes nutritional disturbances which contribute to the later development of "arthritis deformans" [i.e., osteoarthritis] and osteocartilaginous loose bodies. If the fracture unites but later functional stress and strain are too great, the bone collapses and the joint becomes deformed.

Pelvic Arthropathy of Pregnancy. Young[601] amplified his previous report[7] on this condition which affected 0.75 per cent of 4512 pregnant women. The degrees of relaxation of pelvic (sacro-iliac and pubic) joints which normally occur during pregnancy are meager and symptomless but in the cases studied they were excessive and produced pain and tenderness in the pubic and sacro-iliac regions which appeared usually about the sixth or seventh month of pregnancy, sometimes earlier. In most cases of such pelvic arthropathy sacro-iliac joints were affected without pubic abnormality. Treatment for mild cases was use of corset and rest, for severe cases com-

plete rest in bed; for those with persistent sacro-iliac backache forcible manipulation (Bankart method, 1932) was best and gave complete relief to 68 per cent of 25 patients so treated.

Diseases of Bursae

General Comment. The general problem of bursitis was discussed by Stimson. Etiology is usually trauma, infection or "toxins." Therapeutic aspiration, stab drainage and incision were condemned; injection of sclerosing fluids was discouraged. Conservative treatment with rubber sponge pressure dressings was recommended. Complete excision was performed when conservative treatment failed. In cases of olecranon and prepatellar bursitis and of inflammation in adventitious bursae Sarma obtained good results by injecting quinine urethane and a 5 per cent solution of sodium morrhuate. Excision was performed for recurrences which were rare.

Special Types of Bursitis. Historical aspects of "miner's elbow" were presented, with old (1842) descriptions of olecranon bursitis.[478] Salsbury discussed the anatomy of the ulnar bursa; in most cases a normal communication exists between the bursa and the digital sheath of the fifth finger.

Hyoid bursitis was described as a new disease entity: Nelson observed 31 cases, mostly in women; etiology was probably infection of nose, throat or teeth. Symptoms included soreness of throat on swallowing or talking, and tenderness at the tubercle of the greater cornua of the hyoid bone. Salicylates gave relief.

Cases of tuberculous bursitis about the femoral trochanter were reported.[586] Stimson discussed olecranon, radiohumeral, iliopectineal, ischial, gluteal, prepatellar and infrapatellar bursitis and problems of bursae of the hamstrings, ankle and foot.

Diseases About the Shoulder Joint: the Painful Shoulder

General Comment. Common lesions producing "painful shoulder" were discussed.[207, 305] Many of them are due, not to "wear and tear" but to "tear and wear," according to Bosworth who noted, at operation, lesions in the following incidence: tendon lesions 24 cases, bursal lesion three cases, exostosis two cases. The tendon lesions included laceration or avulsion of one or more short rotator tendons in 17 cases, complete avulsion of the short rotator cuff in four, calcification or ossification of supraspinatus tendon in two, separation of the supraspinatus and infraspinatus muscles and tendons in one case. Diagrams of all these lesions were published.[59] According to others the commonest cause of painful shoulders is bursitis.[207, 440] In the 104 cases of Patterson and Patterson the following diagnoses were made: bursitis in 70 cases (with calcification in bursa or tendon in 55, without calcification in 15 cases), periarticular inflammation in 15, sprain or subluxation in eight, arthritis in six, rupture of supraspinatus tendon in three, congenital deformity in two. In 53 per cent of Wilson's cases lesions of the sub-

acromial bursa were responsible for symptoms; in others they were due to lesions of bones, shoulder or acromioclavicular joint, muscles, tendons and vessels. The chief designation used by Solomon was "periarthritis," the result of adhesions and cicatricial formation subsequent to subdeltoid or subacromial bursitis. Myocardial infarction was the cause of pain in the shoulder in 17 of 133 cases (Ernstene and Kinell).

[Obviously many different lesions are responsible for pains in the shoulder. It would appear that physicians tend to lump their cases of "painful shoulders" under a favorite diagnosis, whereas surgeons, having explored the lesions, make more varied and specific diagnoses. But from surgical reports the relative incidence of these lesions cannot be determined finally because the patients operated on are likely to have the more serious lesions, ruptures, avulsions, etc.—Ed.]

Subdeltoid or Subacromial Bursitis. Current writers shared the opinions of previous workers [6, 7] that inflammation of these bursa rarely occurs primarily but almost always as a result of lesions in contiguous tissues, the floor of the bursa, the supraspinatus tendon or the musculotendinous cuff made up of the tendons of the supraspinatus and infraspinatus and teres minor muscles. In these tissues attritional changes often occur, with or without deposition of calcium salts, in the middle-aged. The pathogenesis of the lesions was again described.[74, 375, 386, 400, 440, 526, 591, 604] Many calcified bursae are symptomless; in three cases such symptomless bursae were blamed for pains later proved to be due to pulmonary apical neoplasms.[422] Calcifying tendinitis about the shoulder has its counterpart in lesions about other joints such as elbows and knees.[74]

Treatment. For cases of "acute bursitis" or "acute calcareous tendinitis" most physicians recommended the injection of procaine hydrochloride into the affected tissues, aspiration of exudate or calcium containing material, and multiple needling of the bursa under local or general anesthesia.[305, 317, 362, 375, 400, 440, 604] It is the multiple needling, relieving tension in inflamed parts and not the anesthetic agent or the aspiration which is responsible for relief.[589] Most physicians used the "two needle technic." Only one shoulder should be treated at a time; the procedure is best done in hospital.[440] Injection and needling are not so useful in chronic cases. Others [29, 591] preferred removal of acutely inflamed bursal tissue and evacuation of calcium material surgically rather than by "blind needling."

For less acute cases or for those patients who will not permit needling and irrigation, rest in abduction, and physical therapy (diathermy) were advised.[317, 375, 549, 604] Wilson considered diathermy useful in some cases, useless in others. Solomon and Weeks regarded diathermy as contraindicated in acute cases: heat merely increases congestion and tension; cold applications for the first 48 hours were preferred. In chronic cases especially of contractures due to capsular adhesions, relief is often provided by conservative measures: physical therapy and "traction-suspension." [400, 604] Roentgen therapy was considered useful by some [305, 592]: in 16 of 22 cases of bursitis, with or without calcification in which this treatment was used, com-

plete relief was obtained.[592] [Two of us, R.H.F. and J.A.K., have seldom found roentgen therapy valuable in such cases.—Ed.] For chronic cases in which motion is limited by "mature adhesions" manipulation under anesthesia was considered dangerous by some,[400] valuable by others [317, 318, 526] who described their technic and supplemented manipulation by traction in abduction and the use of an exerciser. For ruptured tendons surgical repair is required [400]; a new technic was described.[59]

Diseases of Muscles and Fibrous Tissue

Diseases of Muscles Caused by Trauma. 1. Myositis Ossificans. Twenty-five cases were reported among athletes (Thorndike). The disease begins as an inflammatory process with tumor, dolor and calor. Treatment recommended was rest, the immediate use of cold, and a compression bandage to control hemorrhage, later the use of heat to absorb the hematoma. Massage or exercises should be avoided. In 36 per cent the ossification was entirely absorbed. Operation is only required (12 to 24 months after injury) if joint motion is impaired. [The origin of the term "charley-horse" was given by Thorndike.] Shipley described two cases of ossifying hematoma erroneously considered sarcoma.

Fibrositis. A common cause of disability among soldiers of the British Expeditionary Force (1940) was fibrositis (Copeman). The clinical, laboratory and supposed pathologic features of fibrositis were described in the usual manner.[133, 230, 311] Fibrositis was again separated into primary and secondary types. Slocumb [516] outlined the clinical and laboratory differentiation between primary periarticular fibrositis and early rheumatoid arthritis. The ameliorating effect of jaundice on primary fibrositis was discussed further.[256] Fibrositis of ligaments and muscles of back may simulate visceral diseases, such as chronic cholecystitis, appendicitis, duodenal ulcer, etc., according to Harman and Young. But many cases of so-called fibrositis are really cases of "psychogenic rheumatism" (McGregor).

[It is unfortunate that such a common, or commonly discussed, condition as fibrositis has not been the subject of more original work. As we have stated before, there is probably more copy-work in the discussions on fibrositis than in those of any other "rheumatic disease." One current writer [311] who appended no references to his paper, borrowed with little change large sections from the writings of others outlined in recent Reviews.—Ed.]

1. Etiology; Pathology. No new data were presented.

2. Treatment of Primary Fibrositis. This remains as outlined in recent Reviews. Recommended were removal of infected foci, correction of postural defects, avoidance of mental and physical exhaustion, and various forms of physical therapy: "rest, warmth, purgation, sweating and massage." [133, 311, 577] Massage over tender spots "to break up the fibrous nodules" was again recommended as the most important single remedy.[133, 230, 311] If this does not give relief, the painful spots or tender fibrous

nodules should be needled with 1 to 5 c.c. of 0.5 per cent procaine hydrochloride [133, 134] or with 5 to 30 c.c. sterile 2 per cent procaine.[83, 311] The use of histamine by iontophoresis or by injections was again recommended.[133, 311] Of 30 fibrositic patients given histamine by cataphoresis by Kling 61 per cent were "cured," 39 per cent were benefited. Only two of 13 fibrositic patients given injections of bee venom were improved.[540] In cases of old fibrositis of back muscles manipulation was recommended.[32, 133] To prevent exacerbations of fibrositis patients should try to avoid respiratory infections, chilling, dampness and fatigue.[133, 311]

Dermatomyositis: Primary Polymyositis. Chief anatomic features of this rare disease are nonsuppurative inflammation and degeneration of many muscles or even of the entire skeletal musculature. Articular symptoms may also occur. Among 40 cases of dermatomyositis O'Leary and Waisman noted "arthritis" (not defined) in two, transient arthralgia in four. Swollen joints and flexion contractures were present in two of the five cases of Kinney and Maher. Study of earliest muscle lesions indicated that the primary reaction may be manifested by the sarcoplasm rather than by interstitial cellular infiltration.[431]

Infection or other disease commonly preceded the onset of the disease in the cases of O'Leary and Waisman. Present were varied skin lesions, muscle pain and weakness, vasomotor abnormalities, joint contractures, edema, increased creatinuria and low grade fever. In severe cases death may result, usually from respiratory or cardiac involvement. When the disease is less acute, it may subside, and partial recovery may occur, usually, however, with sequelae. Of 38 patients on whom followup studies were made, 19 died within four months to six years. Other cases were reported.[164, 198, 227 246, 359] English authors [164, 198, 359] after pathologic study of skin and muscles stated their belief that the underlying pathology in dermatomyositis is identical to that of generalized scleroderma: they merely present different aspects of the same disease. Dermatomyositis must be distinguished from generalized scleroderma, trichinosis, disseminated lupus erythematosus, arthritis, Addison's disease, and periarteritis nodosa. Keil discussed the differentiation of dermatomyositis from disseminated lupus.

Treatment is empiric and difficult to evaluate. Fever therapy combined with oxygen inhalation was considered "decidedly of value" in some cases.[431] One hundred grams of wheat germ oil daily were said to be beneficial.[411]

Trichinosis. A rapidly fatal case of trichinosis with myocardial involvement was mistaken for rheumatic fever.[569] High frequency radiation (4.75 megacycles) markedly retards the development of larvae of *Trichinella spiralis.*[274]

Psychoneurotic Rheumatism. Several cases of psychoneurotic (muscular) rheumatism were described by McGregor who explained the pains occurring in these patients as a symbol of the individual's cramped existence (mental strain and emotional disturbance). "Rheumatism without structural change is nearly always psychogenic." Psychotherapy was often successful.

[In most of the cases described by McGregor as well as those discussed by Halliday [6] a diagnosis of "fibrositis" had been made previously. Students of rheumatism would do well to study these case reports so that the diagnosis of fibrositis be not so indiscriminately made.—Ed.]

Miscellaneous Myopathies. Advances in the treatment of the myopathies were discussed (Milhorat). Myasthenia gravis is said to be benefited by prostigmine, ephedrine, guanidine, and amino-acetic acid. Progressive muscular dystrophy occurring in later life may be helped by amino-acetic acid. Quinine is effective in myotonia congenita and in the muscle rigidity of paralysis agitans. Potassium chloride is a specific for familial periodic paralysis.

Miscellaneous Conditions

Periarteritis Nodosa. Clinical features in the 395 reported cases were summarized by Boyd: 280 patients were males, 108 females; the sex of seven was not stated. Rheumatic fever often antedated the periarteritis which suggests with other data, a connection between the two diseases. There was a tendency for articular and neuromyositic symptoms to appear early, often as the first or second symptom to appear. Exclusive of "arthralgias," neuromuscular symptoms affected 129 of the 395 patients. Large joints such as knees, elbows, wrists or "all joints" may be involved. The combination of arthritis, cutaneous lesions and gangrene has occurred. Articular symptoms generally fade into the background as the syndrome progresses. Of 29 new cases reported in 1940, muscle pains were present in all, joint pains and disability in 13, articular swelling in only four. For diagnosis muscle biopsy should be done, but a negative result does not exclude the disease.

Clinical manifestations are protean and bizarre as a result of widespread vascular involvement; common symptoms are fever, nephritis, weakness, tachycardia, loss of weight, hematuria, polyneuritis, gastrointestinal symptoms, anemia, leukocytosis and eosinophilia.[223, 298] Asthma may be a chief symptom [355, 579]; in one such case painful swelling of both ankles was an early symptom.[579] "An eosinophilia, especially with a leukocytosis, in the presence of a rather bizarre symptomatology that does not seem to fit any syndrome should strongly suggest periarteritis nodosa: in one case the eosinophiles increased to 68 per cent of the leukocytes,[355] but eosinophilia only occurs in about 12 per cent of cases. After onset of symptoms patients live an average of only 11 months.[298] But the disease is not always fatal: four of Grant's seven patients were living after one to three years' observation. A few other cases, not cited here, were reported.

Disseminated Lupus Erythematosus. An interesting symposium on this condition appeared.[310, 323, 416, 430, 515, 544] Symptoms in 154 cases at the Mayo Clinic were analyzed. Arthralgia or arthritis was present in 20 per cent of 80 chronic cases, 57 per cent of 44 subacute cases, 63 per cent of 30 acute cases.[416] Indeed the initial picture in this disease may be one of febrile polyarthritis easily mistakable for rheumatic fever. Two such cases were reported with necropsy data.[78, 215] Joints were painful and swollen in six (40 per cent) of 15 new cases reported in 1940. Chief features of the disease are the skin lesions, sensitivity to light, articular symptoms, fever,

anemia, leukopenia (less than 4,500 leukocytes per cubic millimeter) and renal irritation.

The articular symptoms are rarely diagnosed properly unless skin lesions are present and recognized. But joint symptoms often precede the skin lesions by 1.5 months to five years as they did in eight of Slocumb's 10 cases. The former resembled those of fibrositis, rheumatic fever, subacute or chronic rheumatoid arthritis; in one case actual destructive arthritis occurred.

[It is difficult to make a correct diagnosis from these articular and muscular symptoms if the skin lesion is not yet present. But a presumptive diagnosis of disseminated lupus erythematosus sometimes can be made in cases of "fibrositis," in which elevation of the sedimentation rate and leukopenia with or without renal irritation are present, or in cases of atypical "rheumatic fever" which is unresponsive to salicylates and is associated with leukopenia instead of the usual leukocytosis of rheumatic fever. In our experience such a tentative diagnosis has been confirmed in several cases by the subsequent appearance of the typical skin lesions. It is important to make such a diagnosis, for cases have been noted in which marked, even fatal, exacerbations have been precipitated by fever therapy, chrysotherapy, heliotherapy, etc. for supposed rheumatoid arthritis or rheumatic fever.—Ed.]

The pathology of skin (specific), renal and other lesions (nonspecific) was described.[310, 416, 544, 545] A case of acute arthritis, associated with myocarditis, resembling acute lupus erythematosus was reported.[222]

Treatment. Chrysotherapy gave "very gratifying" results in chronic discoid lupus erythematosus.[430] Sulfanilamide was recommended by some,[28, 593, 597] but since it increases some patients' sensitivity to light, O'Leary did not use it. Other remedies were discussed.

Libman-Sacks Syndrome. In 1924 Libman and Sacks described what they regarded as a distinct syndrome: pleurisy with effusion, polyarthritis, leukopenia, especially a characteristic mural and valvular atypical verrucous endocarditis; two of their four patients had lupus erythematosus. Bunim's patient with disseminated lupus demonstrated this endocardial lesion. In eight of 23 hearts from patients with typical acute lupus erythematosus Gross found endocardial lesions similar to those in the cases of Libman and Sacks. Hence he concluded that the two conditions are closely related if not identical.

Other Studies on Joints and Related Tissues

Articular Roentgenography. In 70 per cent of normal persons menisci of the knee can be demonstrated by roentgenograms made with the knee in a position of forced adduction (Evans).

[The method is applicable only to patients without joint effusions. The "abnormal" case reported is not convincing.—Ed.]

Articular Physiology. Kelikian discussed the various components of joints and how they react to disease. Bowie attempted to summarize present knowledge of the physiology of articular tissues.

[The report was presented without sufficient coördination or critical evaluation. Most of the statements are correct, but no differentiation was made between well

founded conclusions and those based on little evidence, as, for instance, the discussion of the protective action of synovial fluid.—Ed.]

From a study of synovial fluid aspirated at death from 29 normal human knee joints, Coggeshall, Warren and Bauer determined the cytology of normal synovial fluid. The average cell count was 63 cells per cubic millimeter. The percentage and absolute number of cell types were: 63 per cent, or 41.7 mononuclear phagocytes, 24.6 per cent or 14.7 lymphocytes, 6.5 per cent or 3.3 polymorphonuclear leukocytes, 4.3 per cent or 2.5 synovial cells and 2.2 per cent or 0.8 unidentified cells. Normal human synovial fluid is a dialysate of blood plasma containing albumin, globulin and mucin.[477] The presence of mucin distinguishes synovial fluid and similar connective tissue fluids from other body fluids that are dialysates of plasma.

Further studies on the permeability of normal and inflamed synovial membranes were reported. Engel observed that all but five of 18 acid dyes entered the normal articular cavities of rabbits and cats following intravenous or intramuscular injection, whereas 10 alkaline dyes did not. Similar differences were observed in spinal and peritoneal fluids. He concluded that alkaline dyes are lipoid soluble and therefore enter cells and are retained by them, never getting to the synovial barrier. Methyl orange (an acid dye that does not enter joints) is likewise lipoid soluble.

[The differences reported were striking. However, the inconsistencies in the case of the 5 acid dyes are hard to explain. Furthermore these results contradict those of Tani (1935) who found that 16 of 26 alkaline dyes did enter joints. The results of the experiments with prontosil did not corroborate what one of us, W. B., observed in inflamed human joints. Engel's interesting findings require confirmation and extension.—Ed.]

The absorption of uroselectan and potassium iodide from joints was found by Adkins and Davies to be radiographically complete in two hours. Absorption was not influenced by (1) motion or immobilization; (2) fluoride poisoning of the synovial membrane, (3) tying of lymphatics. Hence it was concluded that "true" solutions are removed from joints by diffusion to the blood stream, probably a predominantly physical process. The mechanism of removal of other substances from the subsynovial tissues varied with the size of the particle. Adkins and Davies believe that small colloidal particles are removed from joints like "true" solutions, but more slowly. When particles are more than a certain size, probably in the neighborhood of the size of the globulin molecule, removal by both blood capillaries and lymphatics ceases with the exception of the small quantities which enter the lymphatics. Larger particles, 100 microns or more, have no route of direct egress from subsynovial tissues. Shinkawa studied the time necessary for uranin (sodium fluorescin) to appear in urine after its injection into normal and experimentally inflamed joints. Its absorption from joints mildly inflamed with terepine oil was increased initially; after eight hours it was decreased below normal and absorption returned to normal in three weeks. Similar decreased absorption rates were noted in arthritides experimentally produced with staphylococci, *Escherichia coli* and *Bacillus pyocyaneus* (*Pseudomonas aeruginosa*) and in the case of intra-articular transplantation of a sarcoma.

King demonstrated that tissue cells of ganglia and cysts of menisci contain droplets of mucinoid material, which resemble the effects of cellular activity more closely than those of protoplasmic disintegration. The hypertrophied and extremely complex Golgi apparatus of these cells supports the view that the observed cytologic changes are due to cellular activity (secretion) rather than retrogression. King regarded ganglia and cysts of menisci as abnormal "joint spaces."

[The author's illustrations bear out his statements. This important work should be extended.—Ed.]

Further studies by Hills and Lutwak-Mann on the metabolism of articular cartilage confirm the previously reported experiments of Bywaters.[5]

The Silberbergs continued their studies on the growth of bone and cartilage, reporting on the effects of prolonged injections of bovine anterior pituitary extracts, undernutrition, and the combination of thyroidectomy and the administration of anterior pituitary extracts (bovine).

Experimental Infectious Arthritis. Further work on the spontaneous polyarthritis of rats caused by pleuropneumonia-like organisms was reported by Collier and Staverman.

They attempted to produce experimental arthritis in white rats by injecting synovial fluid, pericardial fluid and blood obtained from a patient with rheumatic fever. Long periods of incubation often ensued before arthritis finally developed. When it did, it was considered experimental, not spontaneous. They concluded that "an endogenous origin of the disease in the inoculated rats seems unlikely since white rats have not hitherto shown such changes."

[The authors apparently do not realize that "normal" white rats are frequently infected with pleuropneumonia-like organisms. Therefore much significance cannot be attached to arthritis "induced" in rats by injecting body fluids from patients with rheumatic fever. The arthritis in the rats was probably spontaneous, not experimental.—Ed.]

An excellent account of the naturally occurring and experimentally produced polyarthritis of swine due to an erysipelothrix organism was presented by Collins and Goldie who pointed out its many clinical, roentgenologic and pathologic similarities to human rheumatoid arthritis.

Extensive pathologic and bacteriologic studies were made by Collins and Goldie on nine swine which had natural chronic proliferative polyarthritis of swine due to swine erysipelas. The disease was reproduced experimentally in other swine by intravenous, but not subcutaneous, injections of *Erysipelothrix rhusiopathiae*. Many grossly arthritic joints were sterile. A state of hypersensitivity was not essential for the production of arthritis. Specific agglutinins were not always found in high titer. Comparisons were made between the swine arthritis and human chronic arthritis. The experiments suggested that articular inflammation may continue after infecting organisms disappear. Such a behavior of joint tissues may reconcile the chronicity of human rheumatoid arthritis with the sterility of joints. Perhaps rheumatoid arthritis results from the localization of bacteria in joints after a transient bacteremia, and these bacteria start tissue reactions which continue chronically even after the infecting germs are destroyed. Serologic tests on humans seemed to indicate that human rheumatoid arthritis is not caused by the infection of swine erysipelas.

An acute septic polyarthritis resulted in 45 of 51 albino rats when Rothbard injected Group A hemolytic streptococci isolated from a case of human septicemia.

[The author believed this to be the first account of hemolytic streptococcal arthritis in rats.—Ed.]

Experimentally produced infectious arthritis was treated with various chemotherapeutic agents. Heilman reported that a single injection of gold sodium thiomalate (myochrysine) protected mice against fatal doses of *Streptobacillus moniliformis* whereas neoarsphenamine and sulfapyridine were ineffective. It was proved that gold salts can prevent arthritis from hemolytic streptococci,[154] also that from pleuropneumonia-like organisms in rats.[189] Sabin and Warren obtained similar results with

two insoluble gold compounds (calcium aurothioglycolate and calcium aurothiomalate) in experimental arthritis in mice caused by a pleuro-pneumonia-like organism.

Paleopathology. Students of rheumatism will be interested in Hormell's notes on the history of rheumatism and gout.

Physiology of Muscles. To give hypertonic saline solution intravenously is the only method which will increase the temperature of both skin and muscles, according to Friedlander and his colleagues. Blood flow in muscles of extremities is not directly controlled by the sympathetic nervous system. Investigators can no longer conclude that increased circulation in skin is accompanied by an increased circulation in muscle.

[This paper would have been of more importance had not the subjects all had peripheral vascular disease. A few patients had unilateral vascular disease, but the reader is given no clue as to their identity.—Ed.]

Rheumatism and the War

British Experiences. The incidence of rheumatic diseases in peace time has been fairly high in the British army and even higher in the civil population. Copeman and Horder [280] considered it extremely unlikely that the incidence of rheumatic diseases among British soldiers and civilians would be lowered in war time. Indeed under the latter circumstances which inevitably involve an increase in exposure, nutritional deficiencies and other factors, the incidence would be expected to rise. Copeman [who as major was in charge of a rheumatism center in France with the British Expeditionary Forces in 1940.—Ed.] reported that during the first 4 months of the present war "rheumatic cases" comprised 15 per cent of the total admissions, 26 per cent of all medical admissions, to No. 3 General Hospital. Similar figures were reported from No. 2 General Hospital. Of the first 100 cases studied 15 per cent were of rheumatic fever, 6 per cent were of rheumatoid arthritis, 9 per cent were of osteo-arthritis (generally traumatic), 70 per cent were of fibrositis. The average age of the patients was 29.6 years. "If these figures be taken as representing a fair picture of the incidence of 'rheumatism' in the B.E.F., it follows that there will be at any time 12 to 15 per cent of such cases in every hospital although this may show some seasonal variation." The great problem will be to secure adequate treatment for all these patients, most of whom should thereby be capable of being returned to duty.

Rheumatologists in the War. Only recently has the medical profession in Great Britain studied the problems of rheumatism closely; hence the number of practitioners interested therein is small. It was Horder's belief that in the army their skill should be concentrated so far as possible on the management of rheumatic diseases, that their energies could be best conserved by the establishment of special military and nonmilitary rheumatism centers, from which some could go out as traveling consultants, that these rheumatologists would be best qualified to carry on needed researches, weed out malingerers in the military services and give authoritative opinions

regarding the fitness of recruits suspected of having, or being liable to, the rheumatic diseases. Horder further recommended that the British army, navy and air force should each have rheumatism units attached to their training centers and hospitals. These views were shared by the writer of an editorial [170] who stressed the superior qualifications of the rheumatologist in diagnosing and treating the confusing diseases of muscles and joints: he best knows the value of this and that remedy. "The most useful contribution rheumatologists can make to the war effort is to bring this experience to bear on joint diseases as a whole. . . . It may be that war will achieve in a few years what under peace conditions might have taken a few generations—the recognition of arthrology as a specialty, and the merging of 'rheumatology' with it."

Some of the special medical knowledge that rheumatologists should have in war time, and which they can help to advance, has been touched on here and there in this Review; of chief importance are the newer advances in the treatment of septic arthritis [33] and septic lesions from penetrating war wounds in and near joints.[94, 187, 583] The interesting studies of Stott and Copeman on articular symptoms from epidemic meningococcemia among soldiers and of Bennett and Copeman on rheumatic symptoms associated with rubella among soldiers have been mentioned. Our next Review doubtless will contain much more of these special data.

Physical Therapy and War. The special importance of physical therapy and the rôle of physical therapists in war times was discussed.[196, 229, 267, 518]

One of the outstanding lessons of the first world war concerned the great importance which physical therapy played in the rehabilitation of war wounds. The belated recognition of this fact resulted in needless suffering and disability. Early physical treatment could have reduced greatly the pension costs of disabled soldiers. The "reservicing" of casualties requires trained professional and technical personnel and adequate equipment. The organization of physical therapy for war time needs should be in the hands of those who have made it a special study. It was recommended that a Director of Physical Therapy be appointed to render service to the Ministry of Health. The director should head a central organization to be responsible for (1) the creation of a central register of those qualified in physical therapy, (2) the enlistment of qualified specialists for military and special civil duties, (3) the correlation of their work with those in all other branches of service, (4) an adequate supply of technical personnel to manufacture and keep in repair sufficient apparatus, (5) the control and distribution of all available apparatus, (6) the formation of large physical therapy units in certain base hospitals and smaller units to be made temporarily available to other base or field hospitals as necessary, (7) the continued training of personnel so that efficient surgical and medical teams may be kept available for remedial work. The special value of occupational therapy in military hospitals also was stressed.[229]

As a result of such advice facilities for physical medicine were organized (May, 1939) by the Ministry of Health under the Emergency Hospital Scheme with Sir Robert Woods [610] as consultant adviser in physical medicine to the Ministry of Health. Eleven more or less autonomous administrative regions were established in England and Wales, the London region being divided into 10 sectors. In each sector is a specialist in physical medicine. These specialists constitute the "Medical Per-

sonnel." The "Auxiliary Personnel" comprises 6,000 members of the Chartered Society of Massage and Medical Gymnastics who have volunteered for war service and have been classified as to experience, seniority, etc. The "Equipment Personnel" is responsible for the production and maintenance of needed apparatus of which two simple agents were of preëminent value: (1) various methods for producing heat and (2) electrical currents to stimulate muscle contractions. This personnel is also responsible for space facilities. Under this scheme physical therapy is available for rheumatic patients at all Emergency Medical Hospitals with more than 300 beds.[610]

For the application of physical therapy to rheumatic soldiers in mobile hospitals, evacuation centers or base hospitals without adequate electricity simple nonelectrical methods are required. Several simple methods were improvised by Copeman.

They included a steam bath made up of two towel rails on three sides of an ordinary canvas chair, the whole being covered with layers of sacking under which steam was led through a rubber tube attached to a large tin or kettle boiling on a primus stove; a radiant heat lamp made out of two petrol tins with a sheet of metal behind to act as a reflector, the source of heat being a plate of cast iron or a bundle of gas "elements" placed over a primus stove and allowed to glow to a dull red.

[For his ingenuity and enterprise in devising such methods to apply physical therapy under the difficult circumstances of war Copeman was just awarded the gold key of the American Congress on Physical Therapy, an award also made to three distinguished Americans.—Ed.]

American Preparedness. At the request of the Surgeon General's office, U. S. Army, the American Rheumatism Association has canvassed its members as to their willingness and qualifications for special military service. Groups of senior and junior medical and orthopedic consultants on rheumatic diseases have been established provisionally and data thereon have been transmitted to the Surgeons General of the Army, Navy and Public Health Department. A brief synopsis on the diagnosis and treatment of the common rheumatic diseases has been prepared to be disseminated from the Surgeon General's office as a circular letter to all medical officers in the Army.* American physical therapy consultants and technicians are likewise being mobilized and a primer on the simpler methods of applying physical therapy is in preparation. Coulter[135] and others have discussed the place of physical therapy in the American military service. Physical standards set up for the selection of soldiers under selective service include data on the relative disablement caused by residual or active rheumatic diseases.[401]

The Campaign against Rheumatism

There are three chief goals to be accomplished by the campaign against rheumatism: (1) reduction of the general incidence of the rheumatic diseases by providing better housing and nutrition for the poorer classes, decreasing the industrial hazard provided by exposure to cold and damp and reducing the trauma of industrial work; (2) expansion of existing hospital facilities and convalescent homes through the coöperation of Departments of Public Health; (3) expansion of educational facilities to both laymen and the medical profession (Pemberton and Scull).

Stressed was the need for more British and American hospital facilities. Davidson reported that in Scotland about 1,000 persons with chronic rheu-

* This is scheduled to appear in the Army Medical Bulletin, January, 1942.

matic diseases were treated annually as in-patients in 10 large voluntary hospitals; as compared to 5,000 out-patients. Only a minority of Scottish rheumatic sufferers were receiving adequate treatment. Each piece of physical therapy apparatus was in constant use; each masseuse gave an average of 6,000 treatments. "Since only one of every 100 patients suffering from the severer forms of chronic rheumatic disease is admitted to the voluntary hospitals and since only one of every 20 patients obtains physical therapy, it is clear that no real progress can be made until additional facilities are available. The serious nature of the finances of the large voluntary hospitals in Scotland makes it extremely unlikely that they can erect additional facilities. Hence while the voluntary hospitals must continue to take an active share in the fight against rheumatic diseases, the magnitude of the problem necessitates a national campaign so that local authorities will provide, in selected areas, centers for diagnosis and treatment." [149] This lack of proper facilities in Great Britain was called a "national scandal." [278]

In the United States also arthritis is "a neglected disease" according to Snyder. Arthritic victims lacking the means to finance treatment are almost entirely dependent on the resources of private hospitals and physicians. Most general hospitals consider arthritic patients a nuisance. In the entire United States there is no hospital or institution devoted exclusively to the treatment of arthritis. Very few private hospitals with special facilities for arthritics can treat or hospitalize their patients free of charge. There are 100,000 free beds and over $100,000,000 available for the care of, and research in, tuberculosis. But there are not more than 200 free beds available for indigent arthritics and not more than $200,000 available for research projects to combat the scourge of rheumatism.

Physicians and medical students should be constantly informed as to the extent of the problem, trends of new research and the real value of early diagnosis and treatment.[435, 448] But from past experiences in other crusades against chronic disease, it is known that the medical profession, no matter how outstanding its men, brilliant their research and high their ideals, can accomplish little by itself. The profession can only succeed by arousing the public against the scourge of rheumatism.[524] In the mind of the public must be created a desire for early diagnosis and adequate treatment. If private hospitals cannot provide the latter, an aroused public opinion will guarantee it if necessary by creating subsidized institutions. "The problem should be turned into a project" and physicians as leaders in national welfare are the best group to undertake the project; they should not wait until a public or political solution is thrust on them.[237]

The rôle of local authorities in the fight against rheumatism was outlined in the scheme of the Kensington Borough Council (England) [184] which made rheumatic fever a reportable disease and established the first municipal rheumatism clinic in Great Britain. Local authorities should publicize the existing treatment facilities within their area, introduce poor rheumatic patients

early to treatment centers, inquire into the environmental conditions (dampness, overcrowding) of rheumatic victims, attempt to remedy unsuitable housing conditions, compile statistics on the rheumatic diseases, educate the public with regard to the campaign against rheumatism, and provide antidotes for the fraudulent claims of quacks.

In England the campaign is led by Lord Horder, Chairman of the Empire Rheumatism Council who has published "A plan for national action" which made many specific recommendations. It is stimulating to read the Third and Fourth Annual Reports of the war time activities of the Empire Rheumatism Council.[278, 279] Despite the extreme urgencies of war the Council decided to carry on its diverse activities as far as possible. The war has curtailed the Council's researches only slightly, its facilities for treatment more notably. Certain treatment centers were temporarily closed; one of the Council's laboratories was destroyed by bombs; the evacuation of large numbers of school children interrupted the London County Council's scheme for the prevention and treatment of rheumatic diseases. Despite these difficulties many of the Council's therapeutic and research activities have continued; special projects to improve treatment facilities for rheumatic victims in the fighting forces have been undertaken. Meanwhile the Council has sought to conserve its resources for the time after the war when the inevitable harvest of postwar cripples will need its services. But today's problems must not be neglected even in these troubled times. "Clear thinking will bring the conclusion that the sound way to meet the stress of difficult times is to avoid waste. It is a tragic waste of man-power and of money to allow rheumatic diseases to exact its present heavy toll on our people. Nor should it be forgotten that national security has its firmest foundation in a healthy, contented community." [280]

If the embattled and harassed British Medical profession refuses even to slacken its campaign against rheumatism can American physicians, even though they too are now at war, dare to do other than redouble their efforts?

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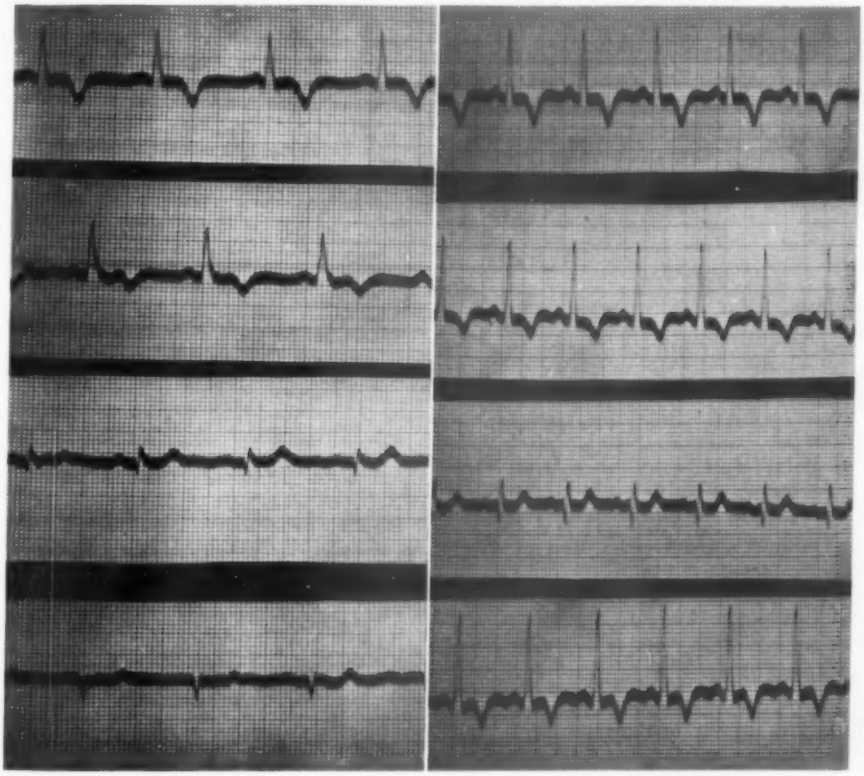
CASE REPORTS

ECHINOCOCCUS CYST OF THE HEART; REPORT OF A CASE*

By C. J. Attwood, M.D., William H. Sargent, M.D., and
Fletcher Taylor, M.D., F.A.C.P., *Oakland, California*

The case here reported presents a most unusual radiological finding in the heart which we believe to be due to a solitary echinococcus cyst situated in the left ventricle.†

R. S., a white female of 57 years, complained of occasional attacks of palpitation and a gradually increasing sensation of "heaviness" in the left chest for four years. Her past history was not remarkable. She had never been outside the United States and since the age of five had resided in California. For the past 15 years she had had



A. *B.*

Fig. 1. Electrocardiograms. *A.* Made July 18, 1938; *B.* Made July 8, 1939.

* Received for publication October 16, 1939.
From Samuel Merritt Hospital, Oakland, California.

† We are indebted to Dr. J. M. McCullough for his permission to examine and report this case.

at least one pet dog which she had permitted to sleep on her bed. At no time had there been severe thoracic pain nor had there been any evidence of cardiac decompensation. She had not been obliged to limit her activities in any way. An electrocardiogram made a year previously (figure 1, *A*) showed evidence, however, of a considerable degree of myocardial impairment. A recent electrocardiogram (figure 1, *B*) showed an increase in the cardiac rate as compared with the previous tracing but did not appear to indicate increasing myocardial damage. At the present time a careful physical examination failed to reveal any evidence of organic pathological change. Blood count and urinalysis were well within the normal. The Wassermann test was negative. The blood pressure was 145 mm. of mercury systolic and 90 diastolic. Skin tests made with hydatid cyst fluid from a recent case and with similar material obtained from Dr. T. B. Magath of the Mayo Clinic were negative. In spite

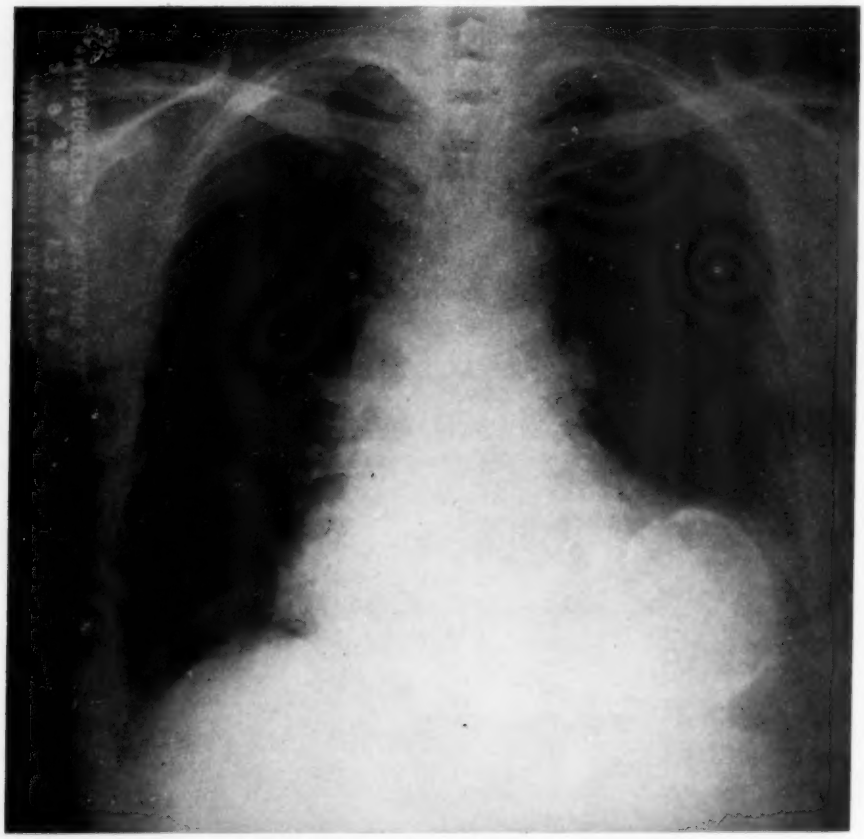


FIG. 2. Two meter postero-anterior view. Note oval, calcified shadow in left side of heart. A thin layer of the myocardium can be seen around the left side of the wall of the calcified shadow.

of the negative skin reaction, however, the roentgen-ray findings in the heart (figures 2, 3 and 4) led us to conclude that this patient was suffering from a solitary echinococcus cyst of the left ventricle.

A two meter postero-anterior projection of the chest (figure 2) showed an oval shadow measuring 6.5 by 8 cm. with a periphery of calcium density situated in the

region of the left ventricle. By viewing this shadow from all directions fluoroscopically and by taking films of the heart in lateral and oblique positions, two of which are reproduced in figures 3 and 4, it was possible not only to show that the object responsible for this unusual shadow was ovoid in form but that its position was within the wall of the left ventricle. A second roentgen-ray examination, made almost a year after the first examination of this patient, showed no discernible change either in the heart or in the calcified body situated within it. We know of no pathological process involving the heart which could produce these radiological findings unless it be an echinococcus cyst. A careful search failed to reveal any evidence of additional cysts located elsewhere in the body.*

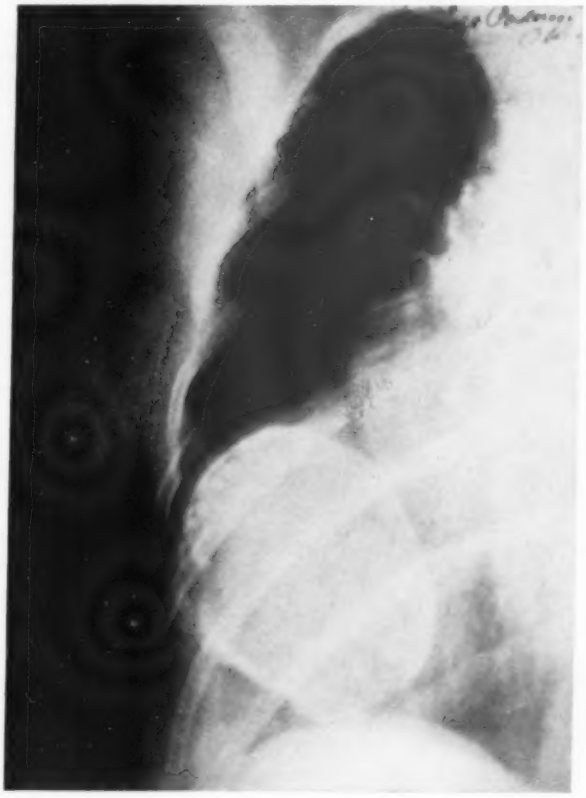


FIG. 3. Left posterior oblique view made with the Buckey diaphragm.

Hydatid cysts of the heart were reported during the seventeenth and eighteenth centuries by Thebesius, Rolfincke and Fanton [1] and early in the nineteenth century by Portal, Dupuytren, Meckel, Price and Morgagni.[2] It has been pointed out by Mills,[3] however, that the term "hydatid disease" was rather loosely used at the time of these early reports and not always restricted to cases in which the pathological changes were caused by the larval or cystic stages of *Taenia echinococcus,* the dog tapeworm. For this reason it seems unlikely that

* On Nov. 28, 1941, the patient was following her normal activities with no additional symptoms.

all the lesions described by these early writers were actually the result of echinococcus disease.

The first paper of significance concerning this rare and interesting condition seems to be that of Griesinger [4] which appeared in the German literature in 1846. Griesinger collected and reported 15 cases which at autopsy were found to have echinococcus disease involving the heart. In 1858 Budd [5] reported five additional cases. One of these, a female of 23 years, was found at autopsy to have a cyst the " size of an orange, full of daughter cysts " situated in the right ventricle. Neisser [6] found 29 reported cases in 1877, and by 1905 Grulee [7] was able to find 55 cases, 26 males and 19 females, in whom there was echinococcic in-

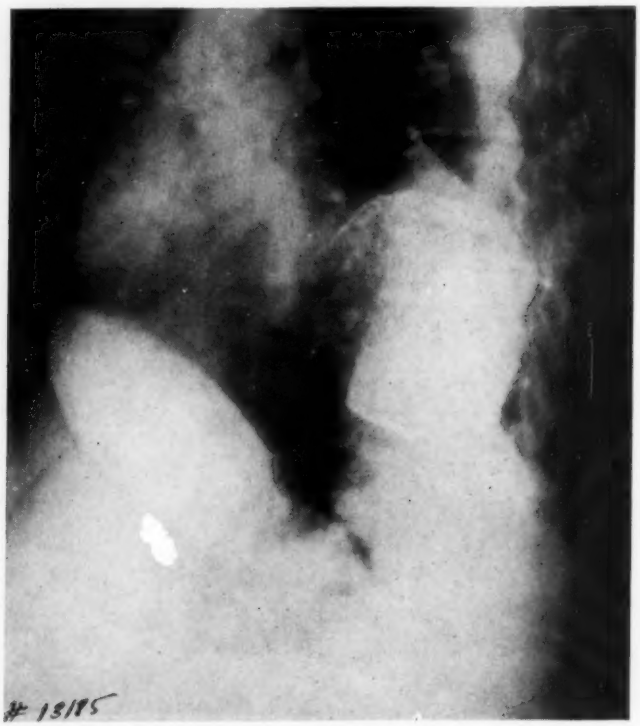


FIG. 4. Left anterior oblique view made with the Buckey diaphragm.

volvement of the myocardium. Their cases ranged in age from seven to 73 years, 41 per cent occurring between the ages of 15 and 25 years. In only 15 of the 55 cases was the heart alone involved. Grulee reported in detail the case of a 27 year old female who was found at autopsy to have an echinococcus cyst the size of a pigeon's egg in the posterior wall of the right ventricle. This cyst had ruptured into the ventricle and multiple embolic cysts were found scattered throughout both lungs, several communicating directly with branches of the pulmonary artery.

Dévé [8] in 1916 was able to find in the literature 105 cases of myocardial involvement in echinococcus disease. In 48 of these cases intracardiac rupture had occurred, the right side of the heart being involved in 28, the left side in 20.

Mills,[8] reviewing the literature in 1922, was unable to find a single case in which the correct diagnosis was made prior to autopsy. He reported the case of a female of 36 years in whom autopsy revealed an echinococcus cyst measuring 4 by 5 cm. situated in the apex of the right ventricle. Four additional cysts were found in the right lung. As far as we have been able to determine the case reported by Mills was the third to be reported from the United States.

In the 17 years following the publication of Mills' paper we have been able to find reference in the literature to 26 additional cases, none of which, however, occurred in North America. Between 1924 and 1929 Hynd,[9] Finny,[10] Heimann,[11] and Corkill [12] reported cases in the British Medical Journal. One of

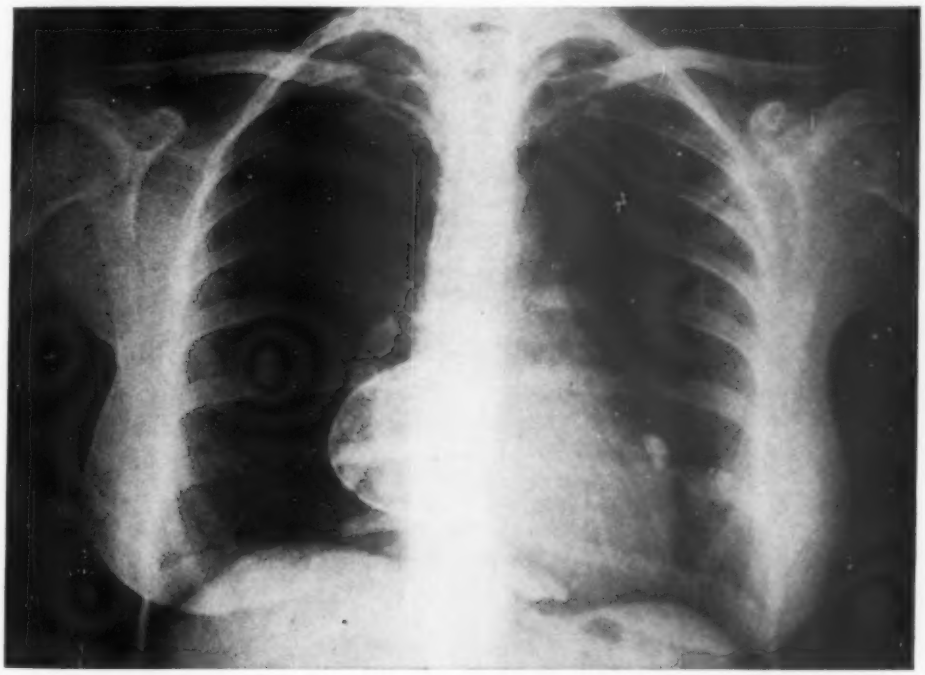


FIG. 5. Postero-anterior film of the chest showing an echinococcus cyst of the heart. Diagnosis proved by operation. Reproduced by permission of Dr. Blondeau.

these cases occurred in England. The others occurred in India, Bagdad and South Africa. In the two cases reported by Corkill and Heimann the cyst was found to occupy the interventricular septum. These hearts have both been preserved. One is at the Royal Iraq College of Medicine at Bagdad; the other in the Museum of the South African Institute of Medical Research at Johannesburg.

A case of multiple echinococcus cysts of the heart was reported by Bacaloglu et al.[13] in 1929. This patient, a male of 27 years, was found at autopsy to have a heart weighing 930 grams, or approximately three times normal. An echinococcus cyst 8 cm. in diameter was found to involve the left auricle and communicated with the auricular lumen. This cyst contained 50 or more daughter cysts each about the size of a pea. Three other cysts of smaller size were situated in the wall of the left ventricle. Two of the ventricular cysts were multilocular.

Examination of the brain showed numerous areas of infarction. Emboli were also found in the liver, spleen, kidneys and adrenal glands. Another case showing secondary involvement of the central nervous system has been reported by Morquio.[14] A child of 11 years, this patient suffered from headache, photophobia, strabismus and mental impairment. No abnormality of the heart could be found on physical examination. The clinical course was one of progressive general failure. At autopsy a small echinococcus cyst was found in the wall

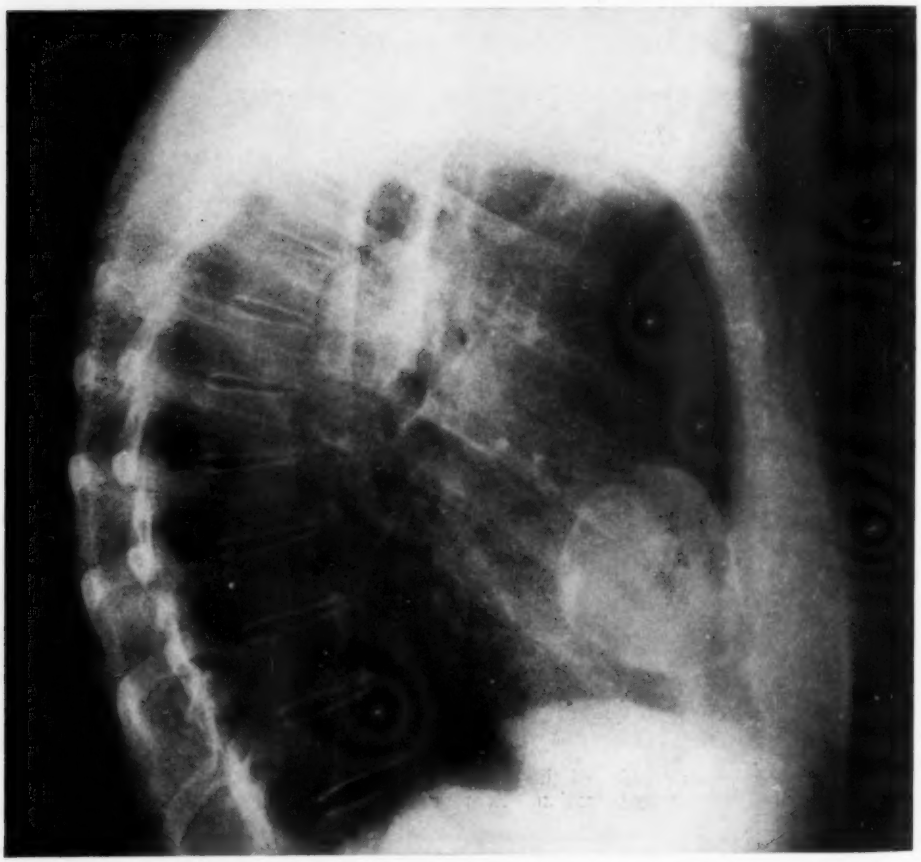


FIG. 6. Lateral film of the chest shown in figure 5. Reproduced by permission of Dr. Blondeau.

of the left ventricle which communicated with the ventricular lumen. Nine secondary cysts were found in the brain and two in the spleen.

A most interesting case has recently been reported from Algeria by Blondeau [15] who has kindly given his consent to the reproduction of his excellent roentgenograms (figures 5 and 6). This was proved to be a case of echinococcus disease of the heart by surgical intervention. The calcifications seen at the inferior and left borders of the cardiac shadow probably represent an "echinococcus seeding" of the pericardium. Dr. Blondeau calls particular attention to the heavy calcification of the cardiac echinococcus cyst which he reported and

points out that in our case the cyst wall was also heavily calcified.[15] This he logically supposes to be due to the resistance offered to the growth of the cyst by a relatively dense tissue such as the myocardium. He considers heavy calcification a very important radiographic sign, "probably even pathognomonic" of a cardiac rather than a pulmonary origin, pointing out that pulmonary echinococcus cysts are rarely calcified at all "while hepatic and muscular cysts grow in resistant tissue and calcify themselves strongly."

It is noteworthy that in the cases of cardiac echinococcosis reported in the literature little or no mention is made of calcification in the cyst wall except in the case reported by Blondeau. Whether or not calcium was looked for could not be determined from the reports. In spite of this fact we are inclined to agree with Blondeau that a spherical mass with a calcified periphery in the heart is most likely to be an echinococcus cyst and it seems justifiable to conclude in the case here presented that the findings in the left ventricle were due to such a cyst. We do not feel that the presence of a negative skin reaction completely rules out such a diagnosis. According to Stitt[17] the intradermal skin test is negative in 13 per cent of cases of echinococcosis. Moreover, since the condition appeared to have remained unchanged for at least a year and probably longer, and since negative skin tests were obtained, it seemed likely that this was a dead or stationary cyst.

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SENSITIVITY TO PEANUT OIL WITH THE REPORT OF A CASE*

By FRANCIS H. CHAFEE, M.D., F.A.C.P., *Providence, Rhode Island*

SINCE Keeney [1] in 1938 first reported the use of a slowly absorbed epinephrine preparation, allergists have found that the use of epinephrine in oil is of great value in controlling intractable asthma. Epinephrine in peanut oil is now available commercially. Although there are few reports in the literature definitely indicating that peanut oil may act as an atopen, there are records of unusual reactions to this preparation.

In 1939 Keeney [2] reported one instance in which urticaria developed after daily use of epinephrine in peanut oil for six weeks. This occurred along with a flare-up of an old sinusitis, and whether a true allergic reaction had occurred was never determined. Palpitation, nervousness, and other reactions probably due to epinephrine itself were reported by Keeney,[2] and by Murphy and Jones.[3] Cohn [4] in 1939 reported a vesicular urticarial reaction that lasted for two days in one patient, and in another a local redness that persisted for 18 hours. Neither of these cases reacted to a skin test to peanut oil.

Peanut oil is a common vehicle for hormonal products, and with their widespread use it is surprising that more untoward reactions are not reported. Levison and Harrison [5] in 1939 reported a papular erythematous rash after the use of theelin. Scratch tests were negative, but intradermal skin tests with peanut and cotton seed oils gave an immediate reaction to both. A few days later scattered areas appeared similar to the original eruption. Davis [6] reported a shock-like reaction to injections of estrogenic preparations. Skin tests with the pure oils were not done, but positive reactions to the products themselves were obtained. Eating peanuts caused a gastrointestinal upset in this patient.

CASE REPORT

A 32-year-old colored housewife entered the Allergy Clinic of the Rhode Island Hospital in March 1939 with a history of hay fever and asthma for the preceding nine years, occurring from August 15 to the time of frost. Her asthma was severe enough to have caused many hospital entries during the fall months. Family history showed the daughter to be highly allergic. Skin tests were positive to ragweed and timothy. She was given preseasonal ragweed therapy only. During June and July she had mild wheezing, and with the onset of the ragweed season her asthma became severe. Epinephrine, 1:1000 solution, gave considerable though temporary relief. During September her asthma continued, and aminophyllin, 0.5 grams intravenously, was necessary on several occasions. On September 19 she visited the Accident Room of the Rhode Island Hospital in a severe asthmatic state. Adrenalin in peanut oil was administered intramuscularly for the first time. A cramp-like pain at the site of injection immediately occurred, lasting an hour or two, and four hours later the site was reddened and raised over an area two inches across. It was described by the patient as being like a "bee sting" and lasted four to five days. Due to the continuation of asthma, the patient administered adrenalin in peanut oil to herself at least 10 times in the course of the next three weeks. Each injection not only gave a similar local reaction, but all previous sites flared up. Complete relief from asthma was not obtained, but her symptoms were ameliorated by adrenalin in peanut oil. Finally she

* Received for publication June 10, 1940.

was forced to discontinue the drug because of pain at the site of injection and the development of a generalized urticaria which lasted for 24 hours. Epinephrine in sesame oil was then administered on 12 different occasions with no ensuing reaction. Good therapeutic results were obtained. On November 27, when asthma-free, the patient was skin tested in the Clinic by the scratch and intradermal methods with adrenalin in peanut oil, theelin in peanut oil, and epinephrine in sesame oil. Positive reactions were obtained in each instance to the peanut oil products, the erythema being at least one-half inch in diameter and persisting for over 24 hours. Further questioning at that time elicited the fact that the patient avoided eating peanuts as she thought that they made her wheezy. A scratch test to peanuts, however, was negative. Pure peanut oil was obtained through the courtesy of Parke Davis & Company, and the patient was tested with this on February 23, 1940. Again positive reactions were obtained by the scratch and intradermal methods. Eight days later they were still strongly positive.

Summary

A case is presented in whom there was an allergic reaction to peanut oil confirmed by skin test. A review of the literature is given.

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EDITORIAL

THE DAYS AHEAD

WITH the declaration of war the long months of uncertainty and disagreement have ended like a dark dream and we face our enemies a strong and united Nation. The road to victory may be long, and progress will be won only with toil and anguish. Nor when military victory comes can we be content. The task goes on beyond that day when our opponents have surrendered their arms. The test of our true greatness as a Nation will be the establishment and the enforcement of a just and a lasting peace. If we and our allies should fail once more in the holding of that precious gift of peace then we would be unworthy of the men who fought and died.

The medical men in war assume heavy burdens, but they are already disciplined. Long hours, emergencies, panic, tears and blood are no new acquaintances to the doctor. We have a high tradition of service in wartime and we shall rise equal to it. Those who serve with troops in the forward zone, those who staff the military hospitals, and those who carry double loads in civilian practice will all be playing their part in winning this war. Let us each be sure where our duty lies and count no cost too great for the doing of it.

Above all when victory has been won in the field let us who will have seen the bloody and broken bodies of our wounded and our dead, remember their right to a peace that will be a fitting monument to their valor.

REVIEWS

A Manual of Allergy. By MILTON B. COHEN, M.D. 156 pages; 19 × 12 cm. Paul B. Hoeber, Inc., New York City. 1941. Price, $2.00.

This volume is small, practically of pocket size, is simply but attractively bound, and typographically quite satisfactory. There are 143 pages of text which are clearly and logically divided into 15 chapters.

A brief but lucid presentation of general principles requires a nice selection of facts. Dr. Cohen has accomplished this difficult feat as well as or better than any other author known to the reviewer.

However, not as much can be said for this book as a manual, which term suggests its use as a guide for the practical application of allergic diagnostic and therapeutic methods. The failure of the volume along these lines is suggested by the fact that the entire subject of bronchial asthma is covered in 13 pages of this small volume. The reviewer feels that all attempts at over simplification in this highly technical subject are doomed to failure.

As an attempt to etch in clearly and simply a background of information about a complex subject the book is more than successful. As an attempt to produce a simplified manual of allergy it is a failure, not because of the author's shortcomings, but because he has attempted the impossible.

H. M. B.

Nitrous Oxide-Oxygen Anesthesia. By F. W. CLEMENT, M.D. 274 pages; 24 × 15.5 cm. Lea and Febiger, Philadelphia. 1939. Price, $4.00.

"This volume is dedicated as a memorial tribute to the life work and achievements of E. I. McKesson, M.D., F.I.C.A. in the specialty of anesthesia" and sets forth his philosophy and the technic of methods for the use of nitrous oxide and oxygen which he worked out during his lifetime. It is an authoritative treatise on this method of anesthesia, but its value as a practical guide for others is decreased by the fact that in the detailed description of technic the use of the McKesson machine only is described.

A complete explanation and rationalization of the signs of nitrous oxide-oxygen anesthesia are given. The importance of respiration and muscular signs is stressed, while phonation and color are shown to be deceptive and unreliable as they bear no relation to the depth of anesthesia in different individuals. Evaluation of the patient as an anesthetic risk, premedication, charting and signs of approaching shock are well presented.

The rôle of carbon dioxide in respiration is treated in a most thorough manner. The author shows that there is "no fixed relationship between cyanosis and physiological anoxemia." The famous "secondary saturation" is carefully described, explained and declared to be less dangerous than essential oxygen want during prolonged deep narcosis.

Dr. Clement reiterates the importance of a clear airway and shows that obstruction to breathing causes alterations of the normal physiologic processes. His methods of treating respiratory obstruction are rational and simple and show great clinical knowledge. The chapter on endotracheal anesthesia contains a series of very helpful anatomical sketches showing the method of intubation by either the nasal or oral route with or without a laryngoscope. Although the author gives elaborate instruction for administering nitrous oxide-oxygen for major abdominal operations,

he admits that even the McKesson technic in his hands will not produce the relaxation obtained with ether or spinal anesthesia.

There is no doubt left in the reader's mind of the clinical ability and knowledge of the author in the administration of nitrous oxide-oxygen anesthesia. His presentation of the subject is most convincing. The book is a fitting tribute to the late Dr. McKesson and should, as intended, preserve for anesthetists the knowledge which he so painstakingly acquired.

M. J. N.

Dermatologic Therapy in General Practice. By MARION B. SULZBERGER, M.D., and JACK WOLF, M.D. 680 pages; 21 × 14.5 cm. Year Book Publishers, Inc., Chicago. 1940. Price, $4.50.

This book should prove to be very helpful to physicians who are not well acquainted with dermatologic therapeutics. The material is well selected, the arrangement is well planned, and the book is easily readable. The methods of treatment of the more common dermatoses are presented in a practical manner. The treatments for several rare dermatoses, such as Riehl's melanosis, erythrose pigmentaire peribuccale, epidermodysplasia verruciformis, and xeroderma pigmentosum are included, whereas the reader is referred to pediatric textbooks for descriptions of the treatment of impetigo of the newborn, and the treatment of the jigger or harvest mite is omitted from the index and referred to only briefly in the text. At the moment treatment of the latter disease is an important consideration of medical officers in the army.

Local anesthetics are recommended for treatment of pruritus ani and vulvae. The reviewer does not share the authors' opinion of their usefulness, and they often act as sensitizers. Some of the proprietary remedies and the "sulfa" drugs now recommended for topical applications had not been in use sufficiently long for a proper appraisal of their worth when the book was published. The chapters on syphilis are very well presented but suffer from the brevity of the usual short textbook. The statement that aldarsone is preferable to tryparsamide is the authors' opinion and not a time tested fact.

None of the criticisms mentioned are sufficient to prevent this book from being one of the most practical, modern treatises on the therapy of skin diseases.

F. A. E.

Roentgen Interpretation. By GEORGE W. HOLMES, M.D., and HOWARD E. RUGGLES, M.D. Sixth Edition, thoroughly revised. 364 pages; 24 × 15.5 cm. Lea and Febiger, Philadelphia. 1941. Price, $5.00.

What has been said about previous editions of the book can be said again about this edition. All radiologists of this country, and many in foreign lands, are familiar with "Holmes and Ruggles." The comprehensiveness and simplicity of this volume on roentgen interpretation have also made it popular with specialists in other fields. The purpose of the first edition in 1919 was to furnish "practical aid to those in search of a working knowledge of roentgen interpretation." Subsequent editions have kept the working knowledge up to date.

The sixth edition is not very unlike those preceding. The subject matter and illustrations have been reviewed, some of the latter having been replaced. Included in this volume are comments on new procedures developed in the past few years, such as visualization of the heart chambers, body section roentgenology, spot-film gastrointestinal work, Miller-Abbott intubation of the intestinal tract, and others. The bibliography has also been revised and brought up to date. Those who are familiar with previous editions will still find the sixth edition an asset to their libraries.

W. L. K.

Biology of the Laboratory Mouse. By the Staff of The Roscoe B. Jackson Memorial Laboratory. Edited by GEORGE D. SNELL. 497 pages; 23.5 × 16 cm. The Blakiston Co., Philadelphia. 1941. Price, $7.00.

The laboratory rat and mouse are the true guinea pigs of science. A contribution to the biology of one can often be applied to the other, so similar are these two species of rodents. Although the biology of the rat was summarized some years ago, we have had to wait until now for an authoritative treatment of the biology of the mouse. The staff of the Jackson Memorial Laboratory is well qualified to make this contribution. The collection of this material from widely scattered articles represents in itself a large piece of work. In addition, however, the authors have worked out many of the problems to which no answer could be found in the literature.

The general investigator will find of most interest the chapters on Embryology, Histology, and Reproduction, as well as those on Parasites and Diseases. The remainder of the book (about one third) deals with genetics and tumor work, as it has been in these fields that mice have been of greatest use.

Each chapter ends with a bibliography giving complete titles and laying before the reader a vast store of information. The emphasis on essentials and the many illustrations and tabulations add greatly to the readability of the book.

E. G. B.

COLLEGE NEWS NOTES

Gifts to the College Library

We gratefully acknowledge receipt of the following gifts donated to the College Library of Publications by Members:

Books

Harry G. Armstrong, F.A.C.P., Major (MC), U. S. Army—"Fit to Fly";
Dr. Jacob C. Geiger, F.A.C.P., San Francisco, Calif.—"1940 Year Book of Public Health" and "1941 Year Book of Public Health";
Dr. Franklin H. Top (Associate), Detroit, Mich.—"Handbook of Communicable Diseases."

Reprints

Dr. M. Meredith Baumgartner (Associate), Janesville, Wis.—1 reprint;
Dr. J. Edward Berk (Associate), Philadelphia, Pa.—2 reprints;
Dr. Edward G. Billings, F.A.C.P., Denver, Colo.—2 reprints;
Dr. William C. Boeck, F.A.C.P., Los Angeles, Calif.—2 reprints;
Dr. Julius P. Dworetzky, F.A.C.P., Liberty, N. Y.—3 reprints;
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Dr. Enrique Koppisch, F.A.C.P., San Juan, P. R.—1 reprint;
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Dr. Thomas O. Nuzum (Associate), Janesville, Wis.—1 reprint;
Dr. Aaron E. Parsonnet, F.A.C.P., Newark, N. J.—1 reprint;
Dr. Harold E. Richardson, F.A.C.P., St. Paul, Minn.—1 reprint;
Dr. Walter M. Simpson, F.A.C.P., Dayton, Ohio—3 reprints;
Dr. Elliott P. Smart, F.A.C.P., Murphys, Calif.—5 reprints;
Dr. Ramon M. Suarez, F.A.C.P., San Juan, P. R.—2 reprints;
Ralph M. Thompson, F.A.C.P., Major (MC), U. S. Army—1 reprint;
Charles H. A. Walton (Associate), Lt. Col., R.C.A.M.C.—3 reprints.

A recent contribution to the College Library of Publications by Members is that of a booklet entitled, "Convalescent Care," edited by Dr. George Baehr, F.A.C.P., containing the proceedings of a conference on the subject under the auspices of the Committee on Public Health Relations of the New York Academy of Medicine. The book contains the contributions of a very considerable number of College Fellows, including Dr. O. H. Perry Pepper, Philadelphia, Pa.; Dr. Lewellys F. Barker, Baltimore, Md.; Dr. William S. McCann, Rochester, N. Y.; Dr. Russell L. Cecil, Dr. Howard F. Shattuck, Dr. Robert L. Levy and Dr. I. Ogden Woodruff, all of New York, N. Y.

During November the new and revised 1941 Directory of the American College of Physicians was distributed to all Fellows and Associates of the College in good standing. The late appearance of the Directory was due largely to delays in obtaining paper stock because of defense priorities. The volume of the Directory is greatly increasing each time it is published, now consisting of a cloth bound book of 667 pages, much of which has been condensed in type face in order to restrict weight and volume. One of the new features of the Directory this year is the insertion of a record of all the past Annual Sessions of the College.

The preparation of a Directory of this character is a task of rather great proportions. Extreme care has been exercised to prevent errors and omissions. Members are urged to advise the Executive Offices of the College of corrections.

Dr. Alfred Gordon, F.A.C.P., Philadelphia, appears in the Directory as Consulting Neuropsychiatrist to the Philadelphia State Hospital, which should be corrected to read, "Philadelphia Psychiatric Hospital."

Regional Meeting of A. C. P. Members, Virginia

The fall meeting of the Virginia members of the American College of Physicians was held at the Cavalier Hotel, Virginia Beach, Va., on October 7, 1941. In the absence of Dr. Henry Mulholland, President, Dr. Walter Martin, College Governor for Virginia, presided. The chief guest speaker was Dr. James E. Paullin, President-Elect of the College, of Atlanta. Officers elected for the coming year were: Dr. R. Finley Gayle, F.A.C.P., Richmond, Va., President; Dr. Andrew D. Hart, Jr., F.A.C.P., Charlottesville, Va., Secretary.

A. C. P. Regional Meeting Planned for the New England States

The Governors of the New England States will hold a regional meeting of the American College of Physicians at Providence, January 14. General arrangements are in charge of the College Governor for Rhode Island, Dr. Alex. M. Burgess, but the General Chairman in charge of the Program is Dr. Charles F. Gormly, of Providence. Governor Burgess will preside at the scientific session, and Dr. Gormly will act as Toastmaster at the special dinner. There will be clinics in the forenoon at the Rhode Island Hospital starting at 10:00 a.m. Luncheon will be served at the Hospital at 12:30 and the main scientific session will be held at the Medical Library Auditorium from 2:00 to 5:30 p.m. In the evening there will be one of the famous Rhode Island Squantum Club dinners. Dr. Roger I. Lee, President of the College, and Mr. E. R. Loveland, Executive Secretary, will be among the evening speakers. Invitations have also been issued to other College Officers, but at this time the program cannot be fully announced. College members throughout New England are urged to be in attendance.

Regional Meeting of North Carolina Members Held at Chapel Hill

The tenth annual meeting, and the third annual clinical session, of the Fellows and Associates of the American College of Physicians in North Carolina was held at the University of North Carolina School of Medicine, Chapel Hill, October 31–November 1, 1941. Friday afternoon, October 31, was devoted to a symposium on "Ulcerative Lesions of the Colon." The participants in this symposium were:

Dr. Charles D. Thomas (Associate), Sanatorium—"Diagnosis and Management of Tuberculous Ulcerative Colitis";

Dr. Opie Norris Smith (Associate), Greensboro—"Concepts as to the Etiology of Non-Specific Ulcerative Colitis";

Dr. C. Graham Reid (Associate), Charlotte—"Management of Non-Specific Ulcerative Colitis";

Dr. Julian M. Ruffin, F.A.C.P., Durham—"Amebic Dysentery in North Carolina."

Friday evening there was a dinner meeting at which Dr. Charles H. Cocke, F.A.C.P., College Governor for North Carolina, presided, and at which Dr. William

Allan, Professor of Genetic Medicine, Bowman Gray School of Medicine of Wake Forest College presented an instructive and interesting address on "Hereditary Diseases Which Wreck Childhood." Saturday morning, November 1, the following program was presented:

Dr. Rufus Henry Temple (Associate), Kinston—"Functional Flatulence and Its Treatment with Prostigmin Bromide";

Dr. Thomas W. Baker, F.A.C.P., Charlotte—"Coarctation of the Aorta";

Dr. Verne B. Caviness, F.A.C.P., Raleigh—"Sulphocyanates in Blood Pressure Control";

Dr. Mark A. Griffin, F.A.C.P., Asheville—"Chronic Alcoholism: Its Causation, Treatment and Results";

Dr. Frank B. Marsh (Associate), Salisbury—"The Plasma Protein: Its Physiology Relative to the Normal and Failing Peripheral Circulation."

Sixty-three members of the College attended the meeting, as well as a number of officers of the Medical Corps of the U. S. Army from Camp Davis and Fort Bragg, who attended the first afternoon session at the invitation of Governor Cocke. The attendance and the enthusiasm of the members were, perhaps, the best of any meeting.

Since the North Carolina members of the College have decided to alternate their annual regional meetings among the three medical schools of the state, their next meeting will be held at the Bowman Gray School of Medicine of Wake Forest College, during October, 1942.

Dr. Francis G. Blake Appointed to Advisory Council on Medical Education

Dr. Francis G. Blake, F.A.C.P., New Haven, Conn., has been appointed by the President of the College, Dr. Roger I. Lee, as an official representative of the College on the Advisory Council on Medical Education, taking the place of Dr. James H. Means, F.A.C.P., Boston, resigned. The American College of Physicians has two appointees on this Council, the other being Dr. Hugh J. Morgan, F.A.C.P., of Nashville, Tenn. The institutions represented on this Council include the Association of American Medical Colleges, American Hospital Association, Federation of State Medical Boards, Advisory Board for Medical Specialties, American College of Physicians, American College of Surgeons, Association of American Universities, American Association for the Advancement of Science (Division of Medical Sciences), American Protestant Hospital Association, American Public Health Association, Catholic Hospital Association and the National Board of Medical Examiners.

Dr. Henry Bingham Kirkland, F.A.C.P., New York City, will spend most or all of the calendar year 1942 on the staff of the American Hospital in Britain.

Dr. Herman S. Hoffman (Associate), Washington, D. C., has been commissioned a Lieutenant Commander in the U. S. Naval Reserve as an internist for the George Washington Medical School Unit.

Recently the U. S. Navy, in addition to its regular organized Reserve, set up an organization called the Volunteer Reserves. The Volunteer Reserves is to be composed of experts and specialists in the various fields. In the medical division it will consist chiefly of units to be established in various universities composed of men chosen by the university. Each unit will consist of nine specialists—Surgeon, Internist, Orthopedic Surgeon, Otolaryngologist, Urologist, Dentist, etc. The Surgeon and Internist will be considered the principal members of the unit. It is set forth by the

regulations that the members of the units will not be called to active duty as individuals, but only with the entire unit. It is understood further that these units are not to be called to active duty except in case of urgent need, interpreted as actual war or grave national emergency, to be used in base hospitals and on hospital ships.

On October 7, 1941, Dr. Bernard I. Comroe, F.A.C.P., Philadelphia, Pa., addressed the Camden County (N. J.) Medical Society on "Practical Pointers in the Treatment of Arthritis."

During September, 1941, Dr. Herbert T. Kelly, F.A.C.P., Philadelphia, Pa., presented a paper on "The Modern Science of Nutrition in Health and Disease," with a motion picture in technicolor, at the Pennsylvania Meeting on Nutrition and Consumer Problems for Defense in Harrisburg.

Dr. Kelly also presented a paper on "The Significance of the Oral Mucosa and Teeth in Deficiency Disease" at a meeting of the Academy of Stomatology, October 28, 1941, at Philadelphia, Pa.

Dr. Ross M. Lymburner, F.A.C.P., Hamilton, Ont., Canada, was the guest speaker at the Scientific Meeting of the Brant County Medical Society, October 23, 1941, in Paris, Ont. His subject was "The Diagnosis of Certain Types of Anemia with Fundamentals of Treatment."

On September 1, 1941, Dr. Frank S. Horvath, F.A.C.P., was promoted to the position of Professor of Clinical Medicine at the Medical School of Georgetown University, Washington, D. C.

Dr. August A. Werner, F.A.C.P., St. Louis, Mo. addressed the Shreveport (La.) and Fourth District Medical Societies, October 7, 1941, on "The Effect of the Ductless Glands on Growth and Development."

Dr. Baldwin L. Keyes, F.A.C.P., Philadelphia, Pa., has been advanced from Clinical Professor of Psychiatry to Professor of Psychiatry at the Jefferson Medical College of Philadelphia, effective October 1, 1941.

Dr. Nathan W. Chaikin (Associate), New York, N. Y., has recently been assigned as voluntary assistant pathologist to the Metropolitan Hospital, under the supervision of Dr. Andrea Saccone, Director of the Laboratory and Associate Professor of Pathology of the New York Medical College. Dr. Chaikin, since July, 1941, has been studying, under the auspices of the New York Medical College, the microscopic and gross pathological material and autopsies as encountered on the medical and surgical services.

The Medical Society of the State of Pennsylvania will hold its 1942 annual meeting in Pittsburgh, Pa., October 5–8.

The Illinois State Medical Society conducted a postgraduate conference in the Eighth Councilor District at Danville, November 6, 1941. Among the speakers were:

Dr. John R. Vonachen, F.A.C.P., Peoria, Ill.—"Present Status of Vitamin Therapy";

Dr. M. Herbert Barker, F.A.C.P., Chicago, Ill.—"Nephritis";
Dr. Lee C. Gatewood, F.A.C.P., Chicago, Ill.—"Medical Management of Upper Gastrointestinal Tract Ulcer";
Dr. Robert S. Berghoff, F.A.C.P., Chicago, Ill., conducted a heart clinic.

Dr. Harold W. Jones, F.A.C.P., Philadelphia, Pa., addressed the Essex County (N. J.) Medical Society, Newark, October 9, 1941, on "Value of Blood and Plasma in Transfusion."

At a meeting of the Morris County (N. J.) Medical Society, Morris Plains, on October 16, 1941, Dr. Hugo Roesler, F.A.C.P., Philadelphia, Pa., spoke on "Bedside Diagnosis and Treatment of Disturbances of Rate and Rhythm."

Dr. Milton B. Plotz, F.A.C.P., Dr. Burton L. Zohman, F.A.C.P., and Dr. Charles G. Williamson (Associate) have been promoted to Assistant Clinical Professors of Medicine at the Long Island College of Medicine, Brooklyn, N. Y.

The Southern Illinois Medical Association held its 67th Annual Meeting in Murphysboro, November 6, 1941. Among those who participated in the program were:

Dr. Ralph A. Kinsella, F.A.C.P., St. Louis, Mo.—"Medical Management of Nephritis";
Dr. James H. Hutton, F.A.C.P., Chicago, Ill.—"Endocrine Therapy Including That of the Menopause";
Dr. Carl G. Morlock, F.A.C.P., Rochester, Minn.—"Problems of the Small Ulcerating Gastric Lesion."

At a meeting of the North Side Branch of the Chicago Medical Society, October 16, 1941, Dr. Virgil P. Sydenstricker, F.A.C.P., Augusta, Ga., discussed "Vitamin Deficiencies."

On October 29, 1941, Dr. John A. Toomey, F.A.C.P., Cleveland, Ohio, presented a paper on "Infantile Paralysis" at the 16th Annual Clinic of the Highland Park (Mich.) Physicians' Club.

The University of Rochester School of Medicine and Dentistry and the Medical Society of the County of Monroe coöperated with the Medical Society of the State of New York in conducting a Postgraduate Institute in Rochester, N. Y., November 11–13, 1941. Dr. Russell L. Haden, F.A.C.P., Cleveland, Ohio, conducted a forum on "Laboratory Methods in Clinical Medicine."

At one of the evening sessions Dr. John A. Toomey, F.A.C.P., Cleveland, Ohio, presented the Monroe County Medical Society Lecture on "Poliomyelitis."

One of the series of "Lectures to the Laity" sponsored by the Brooklyn Institute of Arts and Sciences, the Medical Society of the County of Kings and the Academy of Medicine of Brooklyn will be presented on March 24, 1942, by Dr. Walter C.

Alvarez, F.A.C.P., Senior Consultant in Medicine, Mayo Clinic, Rochester, Minn. Dr. Alvarez will discuss "Food, Faith and Civilization."

The Central Society for Clinical Research held its 14th Annual Meeting in Chicago, Ill., November 7–8, 1941. Among the speakers were:

Dr. Alvin E. Price, F.A.C.P., Detroit, Mich.—"Sputum Studies in Pneumonia: The Selection of Therapy";

Dr. Elmer L. Sevringhaus, F.A.C.P., Madison, Wis.—"Treatment of Parathyroid Tetany";

Dr. George E. Wakerlin, F.A.C.P., Chicago, Ill.—"Treatment of Experimental Renal Hypertension with Renin";

Dr. Nathan S. Davis, III, F.A.C.P., Chicago, Ill.—"Chronic Sub-Nutrition and Essential Hypertension."

A group of thirty-seven interns, representing fifteen nations of South, Central and Caribbean America, have arrived in the United States to spend a year in United States hospitals and medical schools. These interns have received fellowships for study in this country through the coöperation of the Office of the Coördinator of Inter-American Affairs, the Pan American Sanitary Bureau and other participating institutions. Fellows of the College who are among the members of the committee of sponsors for the plan under which these interns are studying are the following:

Dr. Walter W. Palmer, Bard Professor of Medicine, Columbia University College of Physicians and Surgeons, New York, N. Y.;

Dr. Currier McEwen, Dean and Associate Professor of Medicine, New York University College of Medicine, New York, N. Y.;

Dr. William S. McCann, Charles A. Dewey Professor of Medicine, University of Rochester School of Medicine and Dentistry, Rochester, N. Y.;

Dr. William J. Kerr, Professor of Medicine, University of California Medical School, San Francisco, Calif.;

Dr. Francis G. Blake, Dean, Yale University School of Medicine, New Haven, Conn.;

Dr. William D. Cutter, Secretary, Council on Medical Education and Hospitals, American Medical Association, Chicago, Ill.

The Southern Medical Association held its 35th Annual Meeting in St. Louis, Mo., November 10–13, 1941. Dr. James S. McLester, F.A.C.P., Birmingham, Ala., addressed a Public Session, Monday evening, November 10, on "Nutrition in War Time." On Tuesday evening, November 11, which was President's Night, Dr. Paul H. Ringer, F.A.C.P., President of the Association, Asheville, N. C., delivered an address on "Giants of Yesterday."

Dr. James S. McLester, F.A.C.P., Birmingham, Ala., spoke on "Functional Disorders of the Digestive Tract," and Dr. Philip S. Hench, F.A.C.P., Rochester, Minn., spoke on "Management of Chronic Arthritis," at the 6th Annual Meeting of the Gulf Coast Clinical Society, held in Pensacola, Fla., October 16, 1941.

Dr. Luther Bach (Associate), Newport, Ky., has been chosen one of the Vice Presidents of the Kentucky State Medical Association.

At the recent annual meeting of the Michigan State Medical Society in Grand Rapids, Dr. Henry R. Carstens, F.A.C.P., College Governor for Michigan, Detroit, was inducted into the Presidency.

Dr. Eugene F. Du Bois, F.A.C.P., New York, N. Y., was honored at a dinner October 9, 1941, at the Waldorf-Astoria, to mark his retirement as Physician-in-Chief of the New York Hospital and Professor of Medicine at Cornell University Medical College. Dr. Du Bois has been connected with Cornell University Medical College since 1910. Since 1930 he has been Professor of Medicine, and since 1932, Physician-in-Chief of the New York Hospital. He will continue as Professor of Physiology and Head of the Department of Physiology and Biophysics at the Medical School.

On September 11, 1941, the Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, N. C., was formally opened. Dr. Thurman D. Kitchin, F.A.C.P., President of the College, presided at the opening exercises and Dr. Thomas T. Mackie, F.A.C.P., New York, N. Y., spoke on "The Challenge of a New Medical School to the Faculty, Students and Community."

Wake Forest College School of Medical Sciences, which offered only the first two years in medical training, announced in 1939 that it would move to Winston-Salem and expand into a four year school. The expansion was made possible by a gift from the Bowman Gray Fund, from the late Mr. Gray of Winston-Salem.

Dr. Coy C. Carpenter, F.A.C.P., who was Dean of the two year school of Wake Forest will continue as Dean of the Bowman Gray School of Medicine.

The Saranac Lake Medical Society and the Osler Club, Saranac Lake, N. Y., have announced the following winter program of lectures:

January 28, 1942, "Newer Chemotherapeutic Methods"—Dr. Norman J. Plummer, F.A.C.P., New York, N. Y.;

February 4, 1942, "Hematologic Aspects of Tuberculosis of the Spleen and Lymph Nodes"—Dr. William P. Thompson, F.A.C.P., New York, N. Y.;

February 11, 1942, "Gabriels Sanatorium Evening"—Dr. John N. Hayes, F.A.C.P., Saranac Lake, N. Y., in charge;

March 4, 1942, "Stonywold Sanatorium Evening"—Dr. Wayne L. Henning (Associate), Lake Kushaqua, N. Y., in charge;

March 18, 1942, "Practical Problems of Peptic Ulcer"—Dr. Sara M. Jordan, F.A.C.P., Boston, Mass.

At the annual meeting of the Pennsylvania Psychiatric Society in Philadelphia, October 9, 1941, Dr. Baldwin L. Keyes, F.A.C.P., Professor of Psychiatry at the Jefferson Medical College of Philadelphia, was inducted into the Presidency. Dr. George J. Wright, F.A.C.P., Professor of Neurology at the University of Pittsburgh School of Medicine, was chosen President-Elect.

Dr. Russell L. Cecil, F.A.C.P., Professor of Clinical Medicine at Cornell University Medical College, was one of the speakers at the 10th Annual Postgraduate Medical Assembly of South Texas, held in Houston, December 4, 1941.

OBITUARIES

DR. EDWARD EVERETT CAMPBELL

Dr. Edward Everett Campbell, F.A.C.P., of Columbus, Ohio, died on July 4, 1941, as a result of an automobile accident which occurred while he was making a professional call.

Dr. Campbell was born in Logan, Ohio, November 23, 1883. He attended the local schools and was graduated from the Starling Medical School of Columbus in 1907. For many years he enjoyed a large general practice in Logan, Ohio. He then became interested in internal medicine and took a postgraduate course at Harvard Medical School and also studied Cardiology in London, England.

He then moved to Columbus, Ohio, where he devoted his entire time to the practice of Internal Medicine. He was a member of the Senior Staff of Grant and Mount Carmel Hospitals of Columbus. He was also a member of the Courtesy Staff of The Starling-Loving University Hospital. Dr. Campbell was a member of the Columbus Academy of Medicine, Ohio State Medical Society, American Medical Association, American Heart Association, and Fellow of The American College of Physicians since 1936. He was an author of several published papers.

Dr. Campbell, to those who knew him well, was a fine friend, a marvelous host, and a man who really enjoyed life. He took great pride in upholding the standard of the American College of Physicians and gave of his full strength to his patients. The College has lost an ardent Fellow, his patients a fine doctor, and his friends a loyal and steadfast companion.

A. B. Brower, M.D., F.A.C.P.,
Governor for Ohio

DR. CLEMENT L. JONES

Dr. Clement L. Jones, F.A.C.P., of Springfield, Ohio, died August 2, 1941, from a coronary accident. Dr. Jones was born in Winchester, Indiana, on April 29, 1876, the son of Dr. and Mrs. Levi Miller Jones, and there he received his early education. He attended Washington and Jefferson College and received the Degree of Bachelor of Science in 1899. In 1903 he was graduated from the Johns Hopkins University School of Medicine, and in 1904 he received the degree of Master of Science from Washington and Jefferson College.

After leaving Johns Hopkins he served as pathologist to a hospital in Vicksburg, Miss., and soon was made an Assistant in Medicine at Starling Medical College in Columbus, Ohio. Dr. Jones was Pathologist at Mount Carmel Hospital in Columbus from 1904 to 1906, and was for many years pathologist at Rickly Memorial Hospital in Springfield, Ohio. He practiced medicine in Springfield for thirty years.

For many years he was a member of the Staff of the City Hospital in Springfield. At his death he was Director of the Department of Medicine of that hospital, and its Cardiologist. He conducted cardiac clinics twice weekly and this service was a source of great pride and satisfaction to him. He was Director of the Springfield Clinical and Pathological Laboratory since 1913.

Dr. Jones served his country with great distinction during the World War. He was formerly Secretary and President of the Clark County Medical Society. He was a member of the Clark County Medical Society, the Ohio State Medical Association, the American Medical Association, the American Heart Association, and The American College of Physicians. He was also a Diplomate of The American Board of Internal Medicine.

Dr. Jones never lacked enthusiasm for his work and constantly sought to keep abreast of the times in all things medical. He was a true friend and a gracious gentleman. The profession and people of Springfield have lost a fine doctor in the passing of Dr. Jones.

A. B. BROWER, M.D., F.A.C.P.,
Governor for Ohio

DR. GEORGE FORDHAM

Dr. George Fordham, F.A.C.P., Medical Supervisor of the Powellton Division of the Koppers Coal Company, died unexpectedly of a heart ailment at his Powellton, West Virginia, home on October 4, 1941, at the age of 63 years. He was born March 4, 1878, in New York City, graduated in pharmacy from the New York College of Pharmacy in 1897, and received his medical degree from the University of Virginia, Department of Medicine, in 1907. Dr. Fordham did postgraduate work at Harvard and the Massachusetts Institute of Technology.

The deceased served as a private in the United States Army during the Spanish American War. In 1917 he was commissioned as a Captain in the Army Medical Corps, and advanced to Lieutenant Colonel in 1919. He served in the American Expeditionary Force in France and was cited by General Headquarters. He also received the silver medal of the Polish Red Cross in 1921, having seen active service with the Polish Army during the defense and retreat from Kiev that year.

During recent years he has been a Member of the Staff at Morris Memorial Hospital for Crippled Children (Milton); Consultant, Dust Investigation, U. S. Public Health Service; Member and former President, Fayette County Medical Society and Society of Industrial Physicians and Surgeons of West Virginia; Member, West Virginia State Medical Association, Association of Industrial Physicians and Surgeons, Association of Military Surgeons, Southern Medical Association and National Safety Council; Fel-

low, American Medical Association and American College of Physicians (1938); author of many published papers.

During his service in Poland, Dr. Fordham married an American Red Cross nurse, Miss Mary Frances Yodzis, who survives. Also surviving is one son, George Fordham, Jr., a medical student at Duke University.

Dr. Fordham was buried with full military honors in Arlington National Cemetery.

ALBERT H. HOGE, M.D., F.A.C.P.,
Governor for West Virginia

DR. GEORGE MACDONALD ALBEE

Maintaining, even to his last hours, his sincere and studied interest in cardiac disease, Dr. George Macdonald Albee died at his home in Worcester, Mass., August 10, 1941. Truly did he "die in the harness"—active to the very end, according to his oft expressed desire. For some weeks he had been made uncomfortable by increasing symptoms of coronary insufficiency, progressing finally to a terminal coronary thrombosis.

He was born in Hopkinton, Mass., in 1871, to parents of old New England lineage. His father, Dr. George Sumner Albee, had been a country practitioner in Hopkinton for many years. After receiving his medical degree in 1893 from New York University Medical College, Dr. Albee practiced a year in Stowe, Vt., and then established his office in Worcester, Mass., for the general practice of medicine.

Following this country's entrance into the first World War, Dr. Albee promptly offered his services to the government, and was ordered to Camp Dix as a Captain in the Medical Corps of the U. S. Army. Here his immediate problem was the historic influenza epidemic of 1918. From Camp Dix he attended a course at the Army Heart Hospital in Lakewood, N. J., and then became Chief of the Cardiovascular Board at Camp Custer, and later at Camp Meade. He received his honorable discharge from the Army in July, 1919.

Before returning to Worcester, he took postgraduate work in the field of cardiac disease at Johns Hopkins Hospital, Baltimore; Peter Bent Brigham Hospital, Boston, The Mayo Clinic, Rochester; and the National Heart Hospital, London. Following this concentration in a subject which was always his most vital interest, he returned to practice in Worcester, where he has ever since been fondly known as "the heart doctor."

He was a member of the Massachusetts Medical Society, a Fellow of the American Medical Association, and a Fellow of the American College of Physicians since 1926. He belonged to the Johns Hopkins Alumni Association and to the New England and American Heart Associations. In 1937 he was certified as a specialist by the American Board of Internal Medicine. Although Dr. Albee, by reason of a somewhat retiring nature,

consistently avoided selection to office in the various local medical societies, he was made a governor of the New England Heart Association the year before his death—an honor which he deeply appreciated. Locally he was a member of the Worcester Club, Tatnuck Country Club, Bohemian Club, Practitioners' Club, Gen. Devens Post of the American Legion and the Military Order of the World War.

Dr. Albee might well be called the dean of cardiology in Worcester. In his long association with the Worcester City Hospital as its Cardiologist, one may call to mind his tender and knowing ministrations to the old fashioned and temperamental electrocardiograph which at one time filled a whole hospital room in its complicated expanse; or one may recall his quick and shrewd estimate of a person's cardiac status, which he could in turn aptly express to the patient by the use of some telling and appropriate aphorism. He indeed filled a big niche in the hospital staff. At the age of sixty-two he suggested that he be "promoted to the consulting staff" and not simply retired—a method of expression which has become standard parlance, when once a staff member reaches that venerable age.

Besides the Worcester City Hospital, Dr. Albee, at the time of his death, was Consulting Cardiologist to Fairlawn, Belmont, Henry Heywood Memorial (Gardner) and Webster District Hospitals, and Hospital Cottages for Children (Baldwinsville).

Dr. Albee eagerly and regularly attended the various conventions of the American College of Physicians and the American Medical Association, as well as the local meetings of the New England Heart Association and the Worcester District Medical Society. He was easy to approach and affable. His practical and working knowledge of cardiology was very effective. This, together with a unique and delightful personality, gave to Dr. Albee a position supreme in professional circles and made him well loved by Worcester's everyday citizenry.

F. Benjamin Carr, M.D., F.A.C.P.,
Worcester, Massachusetts

DR. LOUIS FAUGERES BISHOP, SR.

Dr. Louis Faugeres Bishop, Sr., M.A., M.D., Sc.D., F.A.C.P., was born in New Brunswick, N. J., March 14, 1864, and passed away October 6, 1941, of pneumonia, at his home, 1172 Park Avenue, New York, N. Y.

Dr. Bishop received a liberal education in the schools of his native city. He was a graduate of St. Paul's School, Concord, N. H. He graduated from Rutgers College, B.A., in 1885, and received the honorary degrees of M.A. in 1889 and Sc.D. in 1920 from the same institution. He studied medicine with Dr. William Elmer of Trenton, N. J. In 1886 he entered the College of Physicians and Surgeons of Columbia University, and received his M.D. degree in 1889, thereafter becoming Resident Physician at

St. Luke's Hospital, New York City, 1889–1892. Thereafter he was identified for three months with the Sloan Maternity Hospital, and for five years held an appointment at the Vanderbilt Clinic. Beginning in 1895 he engaged in private practice in New York City, and in 1908 devoted himself exclusively to diseases of the heart and blood vessels. Dr. Bishop was formerly Professor of Diseases of the Heart and Circulation at Fordham University School of Medicine, a former President of the Good Samaritan Dispensary, former Consulting Physician to Mercy Hospital (Hempstead, L. I., N. Y.), and at the time of his death he was Consultant in Diseases of the Heart, Lincoln Hospital, and Consulting Cardiologist to the Sea View (Staten Island) and Goshen Hospitals.

During the World War, he served as Cardiologist on local Advisory Board No. 23, May 3, 1918, through March 31, 1919. He was a member and former secretary (1895–1903) and two years Chairman of the Section on Medicine of the New York Academy of Medicine; member of the New York Pathological Society, Society of Alumni of St. Luke's Hospital, American Society of Tropical Medicine, American Therapeutic Society, American Medical Editors and Authors Society, New York State and New York County Medical Societies, New York Gastro-enterological Association, Society of Medical Jurisprudence, New York Society for the Relief of Widows and Orphans of Medical Men, and American Heart Association; Fellow of the American Medical Association. He was a Director of the New York School for the Deaf; Director of the Y. M. C. A. of New York City; Trustee of Rutgers University; Trustee of the Museum of the American Indian, New York City; a member of the Sons of the Revolution, Founders and Patriots of America, Pilgrims, Holland Society, St. Nicholas Society, New York Genealogical and Biographical Society; a member of the following clubs: University, Metropolitan, Racquet and Tennis, Seawanhaka Corinthian Yacht, New York Athletic, Columbia University, Explorers Club, Maidstone Club, East Hampton (L. I., N. Y.) Fencers Club and the Rotary Club of New York.

Dr. Bishop was author of a host of publications, starting in 1893 with an article dealing with "A New Measurement in the Study of Fever." He published one or more articles annually almost to the end of his career. Among books published by him were: "Blood Pressure" (with four revisions, from 1904 to 1914); "Arterial Sclerosis" (1914, with two revisions thereafter); "Heart Troubles, Their Prevention and Relief" (1920); "A Key to the Electrocardiogram" (1923); "History of Cardiology" (1927); "The Mechanism of the Heart and Its Anomalies" (a translation from the French of Emile Geraudel, 1930).

Dr. Bishop was a Charter Fellow of the American College of Physicians, and played a large part in its founding in 1915 and in its early administration. His name appears on the first roster of physicians declared Fellows of the College "in recognition of their special meritorious services to the

science and practice of medicine." His participation in College affairs covered many years, and he was deeply interested in all of its activities to the end of his life.

Dr. Bishop is survived by his wife, Mrs. Charlotte Dater Bishop, one son, Louis Faugeres Bishop, Jr., M.D., F.A.C.P., a daughter-in-law, Mrs. Kathleen Sinclair Bishop, and four grandchildren.

C. F. TENNEY, M.D., F.A.C.P.,
Governor for Eastern New York

DR. LOUIS LAWRENCE SYMAN

Dr. Louis L. Syman, F.A.C.P., was born in Cleveland, Ohio, in 1871. He pursued his elementary education in Cleveland and was graduated from Wittenberg College with A.B. and A.M. degrees. He received his medical certificate from Starling Medical College in Columbus in 1898. He was Staff Physician at the Springfield City Hospital from 1898 to 1925. During the Spanish-American War he was Recruiting Examiner. During the World War he was a Regimental Surgeon and also Surgeon of the R. O. T. C. of Wittenberg College.

He was a member of the Clark County Medical Society, the Ohio State Medical Society and the American Medical Association. He had been a Fellow of the American College of Physicians since February 25, 1920. He retired from the practice of medicine a number of years ago because of physical disability.

A. B. BROWER, M.D., F.A.C.P.,
Governor for Ohio

DR. WILLIAM HENRY RILEY

Dr. William Henry Riley died August 24, 1941, at the home of his son, William H. Riley, Jr., near Mattoax, Va., after a brief illness. For nearly fifty years he was chief neurologist at the Battle Creek Sanitarium. He was born in Boston, February 5, 1860, and early came to Michigan. He was graduated with a B.A. degree from Battle Creek College and with a medical degree from the University of Michigan in 1886, when he returned as a member of the staff at the Sanitarium. A few years later he was appointed Medical Director of the new Boulder (Colorado) Sanitarium which post he held for eight years. While there he was part-time professor of neurology in the medical department of the University of Colorado. He was married December 23, 1897, to Miss Henrietta M. Zollinger, a graduate of the University of Wisconsin.

On returning to Battle Creek he was appointed professor of neurology in the American Medical Missionary College, which position he held with distinction until the College was merged with a Chicago university in 1914.

In 1912 he spent some months in leading clinics in Munich, Vienna, Dublin and London. He was a Fellow of the American College of Physicians (1923), the American Medical Association, the American Psychiatric Association, and the Society for Research in Mental and Nervous Diseases.

Dr. Riley was a keen student, with an unusually clear, scientific mind. He made many obscure diagnoses and was an outstanding scientific figure in any gathering which he attended. His scientific papers and productions were many. He was a modest, conscientious man, devoted to his patients, and he will long be remembered for his faithful, untiring service to them.

Dr. Riley is survived by his widow, a son, and a sister, Miss Minnie Riley, R.N.

A. B. Olsen, M.D., F.A.C.P.

DR. JOSEPH WIENER

Dr. Joseph Wiener died suddenly at his home in Asbury Park, N. J., September 8, 1941, of a coronary thrombosis. Though only forty years of age Dr. Wiener had established a definite place for himself in his community. He was a 32d degree Mason and a man of wide cultural interests, being especially interested in photography and music. He was beloved by his patients, had the full confidence of his professional associates, and his untimely death cuts short a career which gave promise of great usefulness both as a citizen and as a physician.

Dr. Wiener was born in New York City, October 19, 1901, attended the University of Maryland, where he first took a premedical course, and was then graduated in medicine in 1925. He interned, 1925 to 1927, at the Chestnut Hill Hospital, Philadelphia, and the Ford Hospital, Detroit. In 1927 he took up practice in Asbury Park and received an appointment in the medical O. P. D. of the Pennsylvania Hospital (Philadelphia), which he held for seven years. Also in 1927 he became Attending physician at the Monmouth Memorial Hospital (Long Branch), and the following year was placed in charge of its Cardiac Clinic. In 1933 he was appointed an Assistant Physician, Vascular Clinic, New York Post-Graduate Medical School and Hospital, and recently was made Chief Cardiologist at the Fitkin Memorial (Neptune, N. J.).

He was a member of the Monmouth County Medical Society, the Medical Society of New Jersey, the American Therapeutic Society, and was a Fellow of the American Medical Association. He became a Fellow of the American College of Physicians, December 13, 1936.

Dr. Wiener is survived by a son, Joseph, junior, aged eleven; a brother, Murray, of Washington, D. C.; and a sister, Mrs. Max Warner, of Bradley Beach, N. J.

George H. Lathrope, M.D., F.A.C.P.,
Governor for New Jersey

POSTGRADUATE FACILITIES IN INTERNAL MEDICINE AND ALLIED SUBJECTS

The Board of Regents of the American College of Physicians has directed the publication in the "Annals of Internal Medicine," from time to time, of announcements relating to available educational opportunities in Internal Medicine and the allied specialties, particularly from the standpoint of postgraduate courses.

An attempt has been made, by communicating with the deans of all medical schools in the United States and Canada and with organized postgraduate meetings and societies, to collect all available data. Unfortunately the Executive Office has been unable to obtain replies from all these agencies, and, in some instances, when replies have been forwarded the information is somewhat incomplete. The following announcement of postgraduate courses and postgraduate meetings, therefore, will be supplemented in future reports. For greater detail, consult the institutions.

Part I—Graduate Institutions

Columbia University
New York Post-Graduate Medical School and Hospital
Irving S. Wright, M.D., Executive Officer
303 E. 20th St.
New York, N. Y.

A number of full-time and part-time courses designed to help the physician to keep abreast of modern procedures in the diagnosis and treatment of diseases are offered throughout the year.

Full-time Courses:

300—*Seminar in Internal Medicine*
Two months, beginning January 5, 1942, and April 6, 1942. Registration may be accepted for one month, but preference is given to those who enroll for both months. Fees, $125.00 for one month; $200.00 for two months.

330—*Arthritis and Rheumatic Diseases*
Five days; March 2–6, 1942; Fee, $35.00.

331—*Allergy*
Three weeks; December 1–19, 1941, and April 13–May 1, 1942; Fee, $150.00.

332—*Cardiovascular Diseases*
Three weeks; June, 1942; exact dates not announced; Fee, $75.00.

333—*Acute and Chronic Diseases of the Chest*
Ten days; February 2–13, 1942; Fee, $50.00.

337—*Diabetes Mellitus, Nephritis, and Hypertension*
Five days; March 9–13, 1942; Fee, $35.00.

338—*Therapeutics*
Five days; December 1–5, 1941; Fee, $35.00.

341—*Symposium in Medicine*
Ten days; June, 1942; exact dates not announced. Registration will be accepted for the entire ten days or for either the first or second five-day section. Fees: $30.00 for five days; $50.00 for ten days.

345—*Electrocardiography*
Five days; May 18–22, 1942; Fee, $50.00.

347—*Clinical Interpretations of Laboratory Data*
Five days; June, 1942; exact dates not announced; Fee, $35.00.

348—*Tropical Medicine*
Five days; May 25–29, 1942; Fee, $50.00.

350—*Pulmonary Tuberculosis*
Two weeks; May 4–16, 1942; Fee, $50.00.

351—*Symposium on the Clinical Applications of Chemotherapy and Vitamins*
Five days; February 16–20, 1942; Fee, $35.00.

353—*Metabolism, Including Endocrinology and Nutrition*
Five days; May 11–15, 1942; Fee, $35.00.

1110—*Diseases of the Liver and Biliary Tract*
Six days; June, 1942; exact dates not announced; Fee, $35.00.

1134—*Endocrinology*
Ten days; March 16–27, 1942; Fee, $50.00.

1140—*Peripheral Vascular Diseases*
Five days; December 8–12, 1941; Fee, $35.00.

1142—*Recent Developments in Diagnostic Procedures*
Ten days; January 19–30, 1942; Fee, $50.00.

1143—*Physical Therapy*
Five days; April 6–10, 1942; Fee, $35.00.

Part-time Courses:

The following courses will be offered beginning the week of January 5, 1942, and April 6, 1942. The courses consist of lectures and clinical demonstrations stressing the diagnosis and treatment of the various disease conditions.

301—*Arthritis and Rheumatic Diseases*
Two months; 9:00 a.m. to 12:00 m., Tuesdays; Fee $35.00.

303—*Cardiology*
Two months; 2:00 to 5:00 p.m., Mondays; Fee, $35.00.

304—*Clinical Interpretations of Laboratory Data*
Two months; 9:00 to 11:00 a.m., Wednesdays; Fee, $25.00.

307—*Problems in Diagnosis*
Two months; 9:00 a.m. to 12:00 m., Mondays; Fee, $35.00.

308—*Acute and Chronic Diseases of the Chest*
Two months; 9:00 a.m. to 12:00 m., Thursdays; Fee, $35.00

309—*Diseases of the Thyroid and Other Endocrine Glands, and Nutrition*
Two months; 9:00 a.m. to 12:00 m., Fridays; Fee, $35.00.

310—*Diseases of the Liver and Biliary Tract*
Two months; 11:00 a.m. to 1:00 p.m., Wednesdays; Fee, $25.00.

311—*Gastroenterology*
Two months; 2:00 to 5:00 p.m., Wednesdays; Fee, $$35.00.

312—*Diseases of the Spleen and Clinical Hematology*
Two months; 2:00 to 4:00 p.m., Fridays; Fee, $25.00.

315—*Psychological Aspects of Internal Medicine*
Two months; 4:00 to 5:00 p.m., Fridays; Fee, $15.00.

319—*Peripheral Vascular Diseases*
Two months; 2:00 to 4:00 p.m., Tuesdays; Fee, $25.00.

320—*Gastroscopy*
Three hours weekly for twelve weeks; 9:00 a.m. to 12 m., Wednesdays; May 6–July 22, 1942; Fee, $75.00.

335—*Electrocardiography*
Two two-hour sessions weekly for four weeks; 9:00 to 11:00 a.m., Tuesdays and Thursdays; April 7–30, 1942; Fee, $50.00.

344—*Advanced Electrocardiography*
Two two-hour sessions weekly for four weeks; 9:00 to 11:00 a.m., Tuesdays and Thursdays; May 5–28, 1942; Fee, $50.00.

The New York Post-Graduate Medical School has also scheduled similar courses in neurology and psychiatry, pathology, pediatrics, bacteriology, dermatology and syphilology.

Cook County Graduate School of Medicine
James F. Askin, Registrar
427 S. Honore St.
Chicago, Ill.

Electrocardiography and Heart Disease—Monthly Course, starting first day of each month, except August. Fee, by arrangement.
Roentgenology—Starts every Monday.
Courses in roentgen-ray diagonsis, fluoroscopy and therapy. Fee, by arrangement.

University of Minnesota
The Mayo Foundation
Donald C. Balfour, M.D., Director
Rochester, Minn.

The Graduate School of the University of Minnesota in coöperation with the Mayo Foundation offers full-time courses in the basic sciences and clinical specialties leading to the degree of Master of Science or Doctor of Philosophy. For the Master's degree in clinical subjects, two or three years are required; for the Master's degree without special designation in the laboratory sciences a minimum of one year (three quarters) of residence is required; for the Master's degree with the field named, such as M. S. in Path., three years are required. Fee, $75.00 per quarter for residents of Minnesota; $125.00 per quarter for non-residents.

A limited number of fellowships and assistantships in the various branches of medicine and surgery are offered at the Mayo Foundation under the auspices of the University of Minnesota. These fellowships and assistantships are designed for those who have recently completed their internship following graduation from medical school.

Throughout the year short periods of lectures, demonstrations, etc., are arranged at the Mayo Foundation. These symposia are devoted to a specific subject or field. or to a more comprehensive presentation of material of variable scope. Dates and subjects of the symposia are not announced.

University of Pennsylvania Graduate School of Medicine
Robin C. Buerki, M.D., Dean
36th & Pine Sts.
Philadelphia, Pa.

This institution offers the following opportunities in advanced medical studies to physicians:

Organized Basic University Intramural Graduate Studies in each of the clinical specialties leading to a certificate: Internal Medicine, Pediatrics, Neurology-Psychiatry, Dermatology-Syphilology, Radiology—eight months, October–June, 1942.

University-aegis Graduate Intramural or Extramural Coöperative Continuation Clinical and Thesis Studies in each of the above special clinical fields, or in an approved division thereof, require an additional two or more years of training and lead to the degree of Master of Medical Science. The University does not provide these studies but does coöperate therewith.

Individual Graduate Intramural or Extramural Coöperative or Independent further Continuation Research Studies in the field related to the previously attained Master's degree, which requires an additional one or two years, and leads to the degree of Doctor of Medical Science. These studies are specially authorized and recognized by the University for each doctorate degree, but are not usually provided for.

Specially Planned Intramural or, partially, Extramural Graduate Nonclinical Candidacies in the Medical Sciences require three or more years and lead to the degree of Doctor of Medical Science. These candidacies are usually based on departmental voluntary assistantships, as such posts become available.

The Graduate School of Medicine of the University of Pennsylvania also sponsors personal courses in subdepartmental fields. During the 1941–42 session the following courses in the Department of Internal Medicine will be offered:

Cardiology—William D. Stroud, M.D., Professor of Cardiology.
Eight Thursdays, 48 hours, beginning the first Thursday of January and April, 1942; Fee, $80.00.

Electrocardiography and Cardiac Roentgenology—Thomas M. McMillan, M.D., Associate Professor of Cardiology, and Samuel Bellet, M.D., Instructor in Cardiology.
Five days, 30 hours, dates by special arrangement; Fee, $60.00.

Clinical Gastro-enterology—Henry L. Bockus, M.D., Professor of Gastro-enterology.
Sixteen weeks, 500 hours, dates by special arrangement; Fee, $400.00.

Allergy—Harry B. Wilmer, M.D., Associate Professor of Allergy.
Four weeks, 40 hours, dates by special arrangement; Fee, $150.00.

Diabetes Mellitus—Edward S. Dillon, M.D., Assistant Professor of Diseases of Metabolism.
Two to four weeks, 75 hours, dates by special arrangement; Fee, $150.00.

Part II—Other Medical Colleges

Boston University School of Medicine
Bennett F. Avery, M.D., Dean
80 E. Concord St.
Boston, Mass.

This institution offers the following short courses:

Diagnosis and Treatment of Digestive Diseases
Two weeks, July 6–18, 1942; Fee, $75.00.

Cardiology and Electrocardiography
Two weeks, July 20–August 1, 1942; Fee, $75.00.

College of Medical Evangelists
Walter E. Macpherson, M.D., Associate Dean
Boyle & Michigan Aves.
Los Angeles, Calif.

Postgraduate extension courses are conducted under the auspices of the Committee on Postgraduate Medical Education of the Faculty of the Los Angeles Division of the Medical School in coöperation with the Committee on Medical Education of the Alumni Association of the College. The courses will be conducted on the basis of one class or clinical period each week and will consist of didactic lectures, round table discussions, clinics and demonstrations. The following courses will be offered during the winter quarter, January 4–March 27, 1942:

General Medicine
Twelve hours; Fee, $25.00.

Cardiology
Thirty hours; Fee, $50.00.

Neurology
Ten hours; Fee, $20.00.

Columbia University College of Physicians and Surgeons
Willard C. Rappleye, M.D., Dean
630 W. 168th St.
New York, N. Y.

Throughout the year this institution in coöperation with certain of the leading hospitals in New York City offers courses for continuation training and advanced experience in the clinical fields of medicine. Courses are divided into two groups—those for the general practitioner and those for the specialist. Courses for the general practitioner are designed to present the latest advances in the various fields of medicine with emphasis on diagnosis and treatment, rather than theoretical considerations. Much of the instruction is carried out in small groups at the bedside and in the outpatient clinic. Courses for the specialist in subjects of interest and value are provided in several fields of medicine. The program of these courses is necessarily flexible and registration is limited to those specialists who have had adequate preliminary training and experience.

Courses for General Practitioners

Clinical Cardiography—Montefiore Hospital
Twelve weeks; 1:00 to 4:00 p.m., Thursdays, February 19–May 14, 1942; Fee, $50.00.

Diseases of the Kidneys and Arteries—Mount Sinai Hospital
Twelve weeks; 4:00 to 5:00 p.m., Thursdays, December 11, 1941–February 19, 1942; Fee, $15.00.

Advanced Course in Diseases of the Heart—Mount Sinai Hospital
Ten weeks; 10:30 a.m. to 12:30 p.m., Fridays, February 6–April 17, 1942; Fee, $50.00.

Advanced Course in Clinical Electrocardiography—Mount Sinai Hospital
Eight weeks; 8:30 to 10:30 a.m., Fridays, February 6–April 3, 1942; Fee, $35.00.

Diseases of Metabolism and Practical Dietetics—Mount Sinai Hospital
Eight weeks; 2:00 to 3:30 p.m., Mondays, Wednesdays and Fridays, February 2–March 27, 1942; Fee, $40.00.

Intensive Course in Cardiovascular Diseases—Mount Sinai Hospital
Four weeks; full time, April 6–May 2, 1942; Fee, $100.00.

Intensive Course in Gastro-enterology—Mount Sinai Hospital
Four weeks; full time, April 6–May 2, 1942; Fee, $100.00.

Intensive Course in Medicine—Mount Sinai Hospital
Four weeks; full time, May 4–29, 1942; Fee, $100.00.

General and Special Pathology—Mount Sinai Hospital
Nine weeks; 8:30 to 10:00 a.m., Thursdays and Fridays, February 3–April 10, 1942; Fee, $45.00.

Surgical Pathology—Mount Sinai Hospital
Nine weeks; 8:30 to 10:00 a.m., Tuesdays and Fridays, April 21–June 26, 1942; Fee, $45.00.

Diseases of Children—Clinical Measurements of Intelligence—Mount Sinai Hospital
Six weeks; 2:00 to 3:00 p.m., Wednesdays, February 4–March 25, 1942; Fee, $15.00.

Courses for Specialists

Gastroscopy—Presbyterian Hospital
Three afternoons weekly for two months; dates and hours by special arrangement; Fee, $200.00.

Clinical Radiotherapy—Affiliated Hospitals
Three months; full time, March 30–June 26, 1942; Fee, $250.00.

(This institution and affiliated hospitals offered numerous courses in medicine and medical specialties from October to December, 1941, but because these courses were already underway, they have been omitted.)

Duke University School of Medicine
Wilburt C. Davison, M.D., Dean
Durham, N. C.

This institution conducts clinics and demonstrations in medicine and other specialties 9:00 a.m. to 12:30 p.m. every Saturday, clinical pathological conferences at 5:00 p.m. every Friday and medical staff rounds at 11:30 a.m. every Friday, which all physicians may attend. In addition, the University offers without charge postgraduate internships to practicing physicians for one or two weeks, and in coöperation with the North Carolina State Board of Health, the U. S. Children's Bureau and the School of Public Health of the University of North Carolina, also offers weekly postgraduate courses in obstetrics and pediatrics.

Georgetown University School of Medicine
David V. McCauley, S.J., Ph.D., Dean
3900 Reservoir Rd., N. W.
Washington, D. C.

Postgraduate work at the Georgetown University School of Medicine is limited to a series of fellowships in internal medicine, pathology, pediatrics, radiology, dermatology and syphilology. The course of study in each of these fields extends over a period of at least three years. The University will confer the degree of Doctor of Medical Science upon those graduate students who satisfy the Council on Graduate Medical Studies that they possess the ability to have made adequate progress and to have made a real contribution to the field of knowledge of their respective specialties.

Harvard Medical School
Courses for Graduates
C. Sidney Burwell, M.D., Dean
Frank R. Ober, M.D., Assistant Dean
25 Shattuck St.
Boston, Mass.

This institution has announced the following program of postgraduate courses in internal medicine and the allied specialties for the 1941–42 session:

203—*General Course in Internal Medicine*
A one-month course given during April, May, August and September at the Boston City Hospital; during June and October, at the Peter Bent Brigham Hospital; during November, at the Massachusetts General Hospital. Unlimited registration; Fee, $150.00; Registration Fee, $5.00.

206—*Selected Subjects in Endocrinology and Metabolism*
Dr. Fuller Albright at Massachusetts General Hospital.
August 3–15, 1942; Fee, $80.00; Registration Fee, $5.00.

209—*Clinical Allergy*
Dr. Francis M. Rackemann at Massachusetts General Hospital.
July 6–17, 1942; 9:00 a.m. to 1:00 p.m. weekdays, with two afternoon sessions each week; no Saturday sessions; registration limited to men; Fee, $50.00; Registration Fee, $5.00.

223—*Principles and Practice of Gastro-enterology*
Dr. E. Stanley Emery at Peter Bent Brigham Hospital.
July, 1942; five days a week, mornings and afternoons; Fee, $100.00.

226—*Diagnosis and Treatment of Heart Disease*
Dr. Edward F. Bland, Dr. Howard B. Sprague and Dr. Paul D. White at Massachusetts General Hospital and House of the Good Samaritan.
April and May, 1942; 2:30 to 4:30 p.m., Fridays; Fee, $25.00.

228—*Cardiology*
Dr. Paul D. White, Dr. Howard B. Sprague, Dr. Edward F. Bland and Associates at Massachusetts General Hospital.
August, 1942; six mornings and four afternoons a week; Fee, $150.00; Registration Fee, $5.00.

229—*Advanced Cardiology*
Dr. Paul D. White, Dr. Howard B. Sprague, Dr. Edward F. Bland and Associates at Massachusetts General Hospital.

September, 1942; six mornings and four afternoons a week; Fee, $150.00; Registration Fee, $5.00.

230—*Internal Medicine—Diagnosis and Treatment*
Dr. F. Dennette Adams and Associates at Massachusetts General Hospital.
June 22–July 31, 1942; daily, except Saturday afternoon; Fee, $200.00; Registration Fee, $5.00.

231—*Modern Diagnosis and Treatment of Heart Disease*
Dr. Samuel A. Levine and Dr. Eugene C. Eppinger and Associates at Peter Bent Brigham Hospital.
July, 1942; daily; Fee, $150.00; Registration Fee, $5.00.

233—*Diabetes*
Dr. Howard F. Root and Dr. Alexander Marble at New England Deaconess Hospital. Registration Fee, $5.00.

244—*Cardiology*
Dr. Paul D. White, Dr. Burton E. Hamilton, Dr. Samuel A. Levine, Dr. Ashton Graybiel and Associates at Massachusetts General Hospital, Boston City Hospital, Peter Bent Brigham Hospital and Harvard Medical School. Full-time, twelve-month course, beginning July 1, 1942; admission subject to the approval of instructor; Fee, $600.00; Registration Fee, $5.00.

This institution also conducts three full-time, twelve-month courses in internal medicine, beginning early in September, under Dr. James H. Means and Associates at the Massachusetts General Hospital; under Dr. George R. Minot, Dr. Laurence B. Ellis, Dr. W. Richard Ohler and Associates at the Boston City Hospital; and under Dr. Soma Weiss and Associates at the Peter Bent Brigham Hospital. Admittance to these courses is limited to a small group and admission is subject to the approval of the instructor. Fee, $300.00; Registration Fee, $5.00.

Long Island College of Medicine
Jean A. Curran, M.D., Dean
350 Henry St.
Brooklyn, N. Y.

Postgraduate courses at the Long Island College of Medicine are conducted under the auspices of the Joint Committee on Postgraduate Education of the College and the Medical Society of the County of Kings. The Committee offers a series of three programs during the year. The courses include various branches of medicine and surgery and consist of lectures, demonstrations and clinics at a number of participating hospitals. All of the courses are part-time and are offered for two hours or more one day each week. Any graduate of a registered medical school is eligible to attend and the fee varies in accordance with the number of sessions. The winter program has not yet been announced.

New York Medical College
J. A. W. Hetrick, M.D., Acting Dean
1 E. 105th St.
New York, N. Y.

This institution offers a three-year full-time course, eight months each year, to qualified physicians in the basic and fundamental work of internal medicine, leading to the degree of Master of Medical Science. During this period the student receives an appointment as a non-resident fellow in medicine. The last two years of the course

are spent in an approved residency and in research work. A thesis is required for graduation.

Short courses in Electrocardiography, Peritoneoscopy and Gastroscopy are also offered; dates and fees not announced.

New York University College of Medicine
John H. Mulholland, M.D., Assistant Dean
477 1st Ave.
New York, N. Y.

Graduate Study in Medicine

A full-time three-year course is offered to a limited number of recent graduates in medicine who have had at least two years of internship or its equivalent to pursue graduate work in internal medicine. Problems pertaining to the basic medical sciences as applied to clinical medicine are developed by the students under the guidance of a member of the faculty of the Department of Medicine and in conjunction with other departments of the College of Medicine, according to the nature of the study. Registration Fee, $12.00 for each year of work.

The following short courses are offered:

Internal Medicine

Five mornings a week for a period of one month; 9:00 a.m. to 12:00 m.; eight sessions during the year from October through May; Fee, per session, $50.00.

Course designed for physicians in general practice desiring a practical review of recent advances in diagnosis and treatment.

Clinical Electrocardiography—Louis F. Bishop, Jr., M.D.

Fifteen weeks; 2:30 to 4:30 p.m., Mondays, February 2–May 11, 1942; Fee, $50.00.

Interpretation of the electrocardiogram and its practical application is presented, as well as measurement and analysis of a large number of curves, operation of standard instruments, normal and abnormal electrocardiograms.

Pneumonia—Jesse G. M. Bullowa, M.D., and Staff.

Four-week sessions throughout the year; six days a week, 9:00 a.m. to 5:00 p.m.; Fee, $100.00.

Course includes clinical, radiological, and bacteriological studies of acute respiratory infections, and demonstrations of the diagnosis, course, treatment, pathology, and radiographic appearances of pneumonia.

Radiology—I. Seth Hirsch, M.D., Charles Gottlieb, M.D., and Staff.

Three-month course; 4:00 to 6:00 p.m., Mondays, Wednesdays and Fridays, during the spring and fall sessions; Fee, $100.00.

The course presents general roentgen-ray diagnosis, designed for the general practitioner in medicine and consists of lectures, practical demonstrations and conferences.

Diseases of the Liver and Biliary Tract—Manfred Kraemer, M.D.

Four weeks; five sessions of two hours each; 9:00 to 11:00 a.m., Wednesday, January 7 through February 4, 1942, at Newark (N. J.) City Hospital.

The course will present a comprehensive review of diseases of the liver and biliary tract designed to familiarize the general practitioner with recent advances in diagnosis and treatment. It will consist of illustrated lectures, presentation of cases and laboratory procedures.

Tufts College Medical School
Postgraduate Division
Samuel Proger, M.D., Chairman
30 Bennet St.
Boston, Mass.

The courses announced below are designed for the busy general practitioner who wishes to bring his knowledge up to date. The work is largely given in the New England Medical Center. In addition to the tuition fee noted below, there is a $5.00 registration fee which covers all courses taken within a twelve-month period.

Allergy—Ethan Allan Brown, M.D.
Five days; May 18–22, 1942; Fee, $25.00.

Cardiology—Samuel Proger, M.D.
Five days; May 4–9, 1942; Fee, $25.00.

Dermatology A—Francis M. Thurmon, M.D.
One week; May 18–23, 1942; Fee, $25.00.

Dermatology B—William P. Boardman, M.D.
One week; January 19–24, 1942; Fee, $25.00.

Diabetes—Joseph Rosenthal, M.D.
One week; January 19–24, 1942; Fee, $25.00.

Diseases of the Bone and Joints—Heinrich G. Brugsch, M.D.
One week; March 2–7, 1942; Fee, $25.00.

Electrocardiography—Heinz Magendantz, M.D.
Five days; May 11–15, 1942; Fee, $25.00.

Advanced Electrocardiography—Heinz Magendantz, M.D.
Three days; January 26–28, 1942; Fee, $20.00.

Endocrinology—Charles H. Lawrence, M.D.
Five days; May 25–29, 1942; Fee, $25.00.

Gastro-enterology—Katherine S. Andrews, M.D.
One week; February 9–14, 1942; Fee, $25.00.

Hematology C—William Dameshek, M.D.
Two weeks; July 6–18, 1942; Fee, $75.00.

Hematology D—William Dameshek, M.D.
Nine weeks; 3:30 to 5:00 p.m., Wednesdays, March 4–April 29, 1942; Fee, $15.00.

Internal Medicine—Samuel Proger, M.D.
Four weeks; May 4–29, 1942; Fee, $50.00.

Pediatrics—Elmer W. Barron, M.D.
Four weeks; January 5–31, 1942; Fee, $50.00.

Radiology—Alice Ettinger, M.D.
Four days; January 13–16, 1942; Fee, $25.00.

Fellowships

Through the Bingham Associates Fund, fellowships for postgraduate study are available for physicians practicing in Maine, who are members of the Maine Medical Association. Application should be made to the Chairman. These fellowships are

not available to other New England physicians; the tuition fees, however, are placed at a level calculated to make the courses available to the great body of physicians in New England.

Tulane University of Louisiana School of Medicine
H. W. Kostmayer, M.D., Director of Department of Graduate Medicine
1430 Tulane Ave.
New Orleans, La.

Review Course in Internal Medicine

Six weeks; beginning January 5 and February 18, 1942; Fee, not announced.

Assistantships

This institution offers to a limited number of properly qualified physicians opportunities to become assistants in the Department of Medicine and to participate in the teaching activities of the staff. Such individuals have assigned reading and research opportunities and, in some instances, may shape their work to lead to the degree of Master of Science in Medicine, after a period of not less than two years.

Throughout the year the Department of Graduate Medicine arranges on demand short intensive courses in certain subjects, such as cardiology, pediatrics, etc.

University of California Medical School
Robert G. Sproul, M.D., Acting Dean
The Medical Center
San Francisco, Calif.

The Medical School offers two short refresher courses each year, one in January and one in June. A course in "Clinical Aspects of New Therapy" will be offered January 5–7, 1942. This course will be intensive and is designed to meet the needs of practicing physicians. It will include Sulfonamide Drugs, Drugs Used on Central Nervous System, Organotherapy, Drugs Used in Treatment of Diseases of the Adrenal Glands, New Drugs Acting on the Heart and Circulation, and Clinical Aspects of Nutrition. Registration Fee, $20.00. The subject of the June, 1942, course has not yet been announced.

University of Chicago, The School of Medicine
Victor Johnson, M.D., Dean of Medical Students
58th St. & Ellis Ave.
Chicago, Ill.

Postgraduate work leading to the degree of Master of Science, or the degree of Doctor of Philosophy, may be taken in the clinical departments of the University. Usually one year of work is required for the degree of Master of Science and three years of work for the degree of Doctor of Philosophy. Individual programs, including research work, are planned in consultation with the department in which the work is taken.

This institution also offers the following intensive courses in Gastroscopy under the direction of Dr. Rudolf Schindler:

Advanced Gastroscopy

Course given for a three-month period during the summer, autumn and winter quarters, and is limited to one student per quarter; Fee, $150.00.

Gastroscopy

Two-week course given each month during the summer, autumn and winter quarters, and is limited to three students; Fee, $100.00.

University of Cincinnati College of Medicine
Stanley Dorst, M.D., Dean
Eden & Bethesda Aves.
Cincinnati, Ohio

Cardiology

A two-week intensive course in cardiology is offered by the College of Medicine in coöperation with the Heart Council of the City of Cincinnati during September of each year; Fee, $75.00.

Diabetes

An intensive refresher course in weekly sessions in the treatment of diabetes is offered each spring by the College of Medicine and the Diabetic Council of the City of Cincinnati; exact dates and fees not announced.

University of Georgia School of Medicine
G. Lombard Kelly, M.D., Dean
University Pl.
Augusta, Ga.

The School of Medicine offers only short courses in Electrocardiography, arrangements for which are made on request to Dr. Virgil P. Sydenstricker, Professor of Medicine.

University of Illinois College of Medicine
David J. Davis, M.D., Dean
1853 W. Polk St.
Chicago, Ill.

Postgraduate work is limited to candidates for the degree of Master of Science or Doctor of Philosophy. These courses are full time and require one to three years of study.

University of Kansas School of Medicine
Harry R. Wahl, M.D., Dean
39th St. & Rainbow Blvd.
Kansas City, Kan.

Refresher Courses

The School of Medicine offers four-day refresher courses in all fields of medicine each spring. Work in the sub-specialties of internal medicine, such as heart, chest and tuberculosis, is included. No registration fee for physicians residing in Kansas.

University of Vermont College of Medicine
C. H. Beecher, M.D., Chairman, Committee of Administration
Pearl St.
College Park, Burlington, Vt.

General Medicine

Each spring, usually during May, the College of Medicine in coöperation with the Vermont State Medical Society conducts a graduate assembly in general medicine.

This assembly consists of lectures, clinics, demonstrations, round table discussions and clinical-pathological conferences, conducted by the faculty members of the College. No admission fee for Vermont physicians.

University of Wisconsin Medical School
William S. Middleton, M.D., Dean
408 N. Charter St.
Madison, Wis.

In addition to the opportunities in residencies and research fellowships, the University of Wisconsin Medical School has made the following announcement:

Observation courses have been organized by the Medical Faculty and Staff of the State of Wisconsin General Hospital upon the approval of the Regents of the University of Wisconsin. No stereotyped courses or lectures are afforded, but attendance upon lectures, clinical services and staff meetings of the Hospital is arranged. A stated fee is charged all physicians in attendance upon the clinical services for periods exceeding one (1) month. This fee shall be $100.00 per month or $400.00 per semester and shall be credited to the department to which the physician is assigned. A certificate of attendance shall be granted upon the completion of the course and shall be signed by the President, Dean of the Medical School and chief of the responsible department. No credit toward an advanced degree may be earned by such attendance, nor is it purposed to include the existing residencies in the scope of this recommendation.

Each spring the Medical School offers a one-week course in medicine and pediatrics; Registration Fee, $7.50.

Vanderbilt University School of Medicine
John B. Youmans, M.D., Director of Postgraduate Instruction
21st St. at Edgehill
Nashville, Tenn.

1. Medicine

These courses, which are designed primarily for the holders of Commonwealth Fund fellowships, are given during the summer from approximately mid-June to mid-July. The course is of one month's duration and consists of seminars, conferences and practice work in the wards and the outpatient department in Internal Medicine and allied specialties of dermatology, neurology, psychiatry, metabolic diseases, allergy, diseases of the chest and syphilis.

It is designed to review this field for the general practitioner and acquaint him with the advances in diagnosis and treatment. A limited number of physicians in addition to the holders of Commonwealth Fund fellowships will be accepted under certain conditions. Tuition, $50.00.

2. Syphilis—Medicine 12.

This course is open to county health officers and physicians with appointments in public health units. It is designed to familiarize the health officer with all aspects of the syphilis problem. It offers him the opportunity of studying the individual patient, history taking, physical examination, darkfield and lumbar puncture procedures and treatment.

The student attends each clinic session for a period of four weeks and assists in the conduct of the clinic. A series of lectures early in the course is given to review the clinical and epidemiological aspects of syphilis. The remainder of the time is devoted to field work, under the direction of the epidemiologist. Several such courses

are given from September to April inclusive. Each course is limited to six physicians. No tuition fee.

3. Syphilis—Medicine 13. Postgraduate Course in Syphilis

This course is open to properly qualified physicians wishing to secure special training in syphilis. It is designed to offer training fitting the student for positions of responsibility in syphilis control work.

The physician is expected to take his place as one of the staff of the clinic, to examine and treat his patients, assuming responsibility for them. Opportunity for thorough training is offered in the conduct of a syphilis clinic, the diagnosis of the disease, including darkfield and lumbar puncture procedures and in treatment. Epidemiological field work is to be done under the direction of the epidemiologist of the syphilis clinic.

Physicians will be accepted for such work for a period of six to twelve months, dependent upon the needs of the individual physician. No tuition fee.

4. Syphilis B. Demonstration in Syphilis Clinic Management for Physicians and Nurses

This course is open to physicians and registered nurses. It is designed to give an opportunity to physicians and nurses to observe the management of patients and clinic procedures for a period of two weeks at intervals during the year. Several such courses are given from September to April inclusive. No more than three physicians and two nurses will be accepted during each period. No tuition fee.

5. Graduate Course in Internal Medicine

This course consists of supervised work with patients in the medical outpatient service, including the related specialties; experience in the diagnostic laboratories; assigned reading, seminars and conferences, including pathological and radiological conferences and autopsy study; directed study and seminars in the pre-clinical sciences, particularly physiology and biochemistry. Special investigation of a particular problem in one of the divisions of internal medicine as the basis of a thesis is required. The course extends over a period of one year and is open to physicians who have completed an internship, have had an additional year's experience as assistant resident in medicine or its equivalent and are acceptable to the school. Courses begin July 1 and are limited to six students. Tuition fee, $300.00.

Fellowships

Three fellowships are available for this course described above. These fellowships, which provide tuition, board and lodging, are open to those who meet the requirements mentioned above and will be awarded on the basis of the individual's training and recommendations.

6. Special work in the Department of Medicine may be made available by special arrangement. Tuition and fees according to arrangement.

Further information regarding these courses should be addressed to the Registrar of the School of Medicine, Vanderbilt University, Nashville, Tenn.

Wayne University College of Medicine
Edgar H. Norris, M.D., Dean
1516 St. Antoine St.
Detroit, Mich.

This institution offers graduate courses requiring full-time study and training in a university fellowship, or in an approved medical residency in hospitals affiliated with the College of Medicine. The work in these courses is designed to meet the requirements of the American Board of Internal Medicine. It also offers post-grad-

uate work in the field of internal medicine on a part-time basis in coöperation with the Continuation School of the Wayne County Medical Society. The following are the continuation courses under the direct auspices of Wayne University College of Medicine:

2. *Clinical Examination of the Heart*—William J. Seymour Hospital, Eloise.
Six weeks; 2:00 to 5:00 p.m., Wednesdays, February 18–March 25, 1942; Fee, $5.00.

3. *Clinical Electrocardiography*—William J. Seymour Hospital, Eloise.
Six weeks; 2:00 to 5:00 p.m., Wednesdays, January 7–February 11, 1942; Fee, $5.00.

28. *Review of Current Literature*—City of Detroit Receiving Hospital.
1:00 to 2:00 p.m., Wednesdays, specific dates not announced; no fee.

29. *Therapeutics*—City of Detroit Receiving Hospital.
Four months; 1:00 to 3:00 p.m., Thursdays, January 29–May 28, 1942; Fee, $10.00.

Woman's Medical College of Pennsylvania
Margaret D. Craighill, M.D., Dean
Henry Ave. & Abbottsford Rd.
East Falls, Philadelphia, Pa.

Clinical Cardiology—William G. Leaman, Jr., M.D., Director.

An intensive course covering the clinical application of present day knowledge of heart disease will be presented in two four-hour periods a week, during a period of twelve weeks, beginning January 2, 1942. Case presentations in the ward and the outpatient department are supplemented by exercises in the interpretation of the electrocardiogram and roentgen methods of cardiac diagnosis. The course is given in sections of not less than four, nor more than ten students. Men and women are admitted for this special work; Fee, $100.00.

Part III—Postgraduate and Clinical Meetings

The American College of Physicians
4200 Pine St.
Philadelphia, Pa.

In the November, 1941, issue of this journal the College program of one- and two-week intensive postgraduate courses was announced in detail. The following courses, arranged through the generous coöperation of the directors and the institutions at which courses will be given, have been arranged:

February, 1942, Courses

1. *Allergy*—The Roosevelt Hospital, Department of Allergy, New York, N. Y.
Robert A. Cooke, M.D., F.A.C.P., Director.
2 weeks, February 2–14; Fee, $40.00.

2. *The Diagnosis and Treatment of Heart Disease*—Massachusetts General Hospital and the House of the Good Samaritan, Boston, Mass.
Paul D. White, M.D., F.A.C.P., Director.
2 weeks, February 2–14; Fee, $40.00.

3. *General Medicine*—University of California Medical School and Stanford University School of Medicine, San Francisco, Calif.

William J. Kerr, M.D., F.A.C.P., and Arthur L. Bloomfield, M.D., F.A.C.P., Directors.
2 weeks, February 2–14; Fee, $40.00.

4. *Internal Medicine*—Johns Hopkins University School of Medicine and University of Maryland School of Medicine, Baltimore, Md.
Warfield T. Longcope, M.D., F.A.C.P., and Maurice C. Pincoffs, M.D., F.A.C.P., Directors.
2 weeks, February 2–14; Fee, $40.00.

5. *Gastrointestinal Diseases*—Graduate Hospital, University of Pennsylvania, Philadelphia, Pa.
Henry L. Bockus, M.D., F.A.C.P., Director.
1 week, February 2–7; Fee, $20.00.

Pre-Meeting Courses

6. *Allergy*—Washington University School of Medicine and Barnes Hospital, St. Louis, Mo.
Harry L. Alexander, M.D., F.A.C.P., Director.
2 weeks, April 6–18; Fee, $40.00.

7. *Arthritis and Rheumatic Diseases*—The Mayo Foundation, University of Minnesota, and The Mayo Clinic, Rochester, Minn.
Philip S. Hench, M.D., F.A.C.P., Director.
1 week, April 13–18; Fee, $20.00.

8. *Peripheral Vascular Diseases, Including Hypertension*—The Mayo Foundation, University of Minnesota, and The Mayo Clinic, Rochester, Minn.
Edgar V. Allen, M.D., F.A.C.P., Director.
2 weeks, April 6–18; Fee, $40.00.

9. *Gastrointestinal Diseases*—University of Chicago, The School of Medicine, Billings Hospital, Chicago, Ill.
Walter L. Palmer, M.D., F.A.C.P., Director.
2 weeks, April 6–18; Fee, $40.00.

10. *Internal Medicine*—University of Minnesota Medical School, Minneapolis, Minn.
Cecil J. Watson, M.D., F.A.C.P., Director.
2 weeks, April 6–18; Fee, $40.00.

11. *Tuberculosis*—University of Colorado School of Medicine and Hospitals, Denver, Colo.
James J. Waring, M.D., F.A.C.P., Director.
1 week, April 13–18; Fee, $20.00.

The Twenty-sixth Annual Session of the College, covering internal medicine and its allied specialties and consisting of General Sessions, Special Lectures, Panel Discussions, Hospital Clinics and Demonstrations, will be held in St. Paul, Minn., April 20–24, 1942, with headquarters at the Hotel Lowry and Hotel St. Paul.

For Bulletin of Postgraduate Courses and Program of the Annual Session, send requests to the College.

Colorado State Medical Society
537 Republic Bldg.
Denver, Colo.

The 10th Annual Midwinter Postgraduate Clinics will be held in Denver, Colo., February 19–21, 1942. The meeting will consist of morning lectures, utilizing the

facilities of several of the local hospitals, and afternoon lecture sessions. Program and registration fee, not announced.

For the three days immediately preceding the Postgraduate Clinics the Colorado State Medical Society and the University of Colorado School of Medicine will conduct intensive refresher courses. Subjects and fees, not announced.

Dallas Southern Clinical Society
1133 Medical Arts Bldg.
Dallas, Tex.

The Society has launched a program of courses for the Continuation of Medical Study to be held each year during June, October and January. Intensive courses for the general practitioner and specialist are held in the various branches of medicine and surgery for three-day periods. The courses will be conducted at the hospitals and clinics of Dallas and at Baylor University College of Medicine, and will consist of round table discussions, clinics, demonstrations and pathological conferences. Courses are open to all physicians who are members of a county medical society; registration fee, $5.00.

In addition to the Continuation Courses the Dallas Southern Clinical Society holds an annual Spring Clinical Conference during March of each year. This meeting consists of general assemblies, postgraduate teaching, clinics, round tables, clinical-pathological conferences and scientific and technical exhibits. Any physician who is a member of a county medical society may register. Registration fee, $10.00.

New York Academy of Medicine
2 E. 103rd St.
New York, N. Y.

During October of each year this society conducts a Graduate Fortnight consisting of morning panel discussions, afternoon hospital clinics, evening addresses, scientific exhibits and demonstrations. The subject of the 1942 Graduate Fortnight has not yet been announced. Registration limited to the medical profession; Fellows of the Academy admitted without fee; all others, $5.00.

During the fall and winter each year, the New York Academy of Medicine sponsors a series of Friday afternoon lectures at 4:30 p.m. These lectures are open to the medical profession and to medical students. The following is the program of lectures for this winter:

December 5, 1941, *Cirrhosis of the Liver*—Arthur J. Patek, Jr., M.D.;
December 12, 1941, *Certain Aspects of the Selectivity and Side Reactions of the Sulfonamide Drugs*—William S. Tillett, M.D.;
December 19, 1941, *Recent Advances in Knowledge of Bright's Disease*—Arthur M. Fishberg, M.D.;
January 9, 1942, *Evaluation of Methods of Treating Cancer of the Female Breast*—Frank E. Adair, M.D.;
January 16, 1942, *Clinical Chemistry in General Practice*—William T. Salter, M.D.;
January 23, 1942, *Plasma Proteins in Health and Disease*—Robert F. Loeb, M.D.;
January 30, 1942, *Interrelationships of Ophthalmology and Systemic Diseases*—R. Townley Paton, M.D.;
February 6, 1942, *Prophylactic Treatment of Rheumatic Fever by Sulfanilamide*—Caroline Bedell Thomas, M.D.;
February 13, 1942, *The Pathogenesis, Recognition and Treatment of Gout*—John H. Talbott, M.D.;

February 27, 1942, *Modern Methods of Diagnosis in Disorders of the Gallbladder*—R. Franklin Carter, M.D.;
March 6, 1942, *Indications for Surgery and the Surgical Treatment of Diseases of the Gallbladder*—Thomas H. Russell, M.D.;
March 13, 1942, *Recent Advances in Certain Renal Surgical Problems*—George F. Cahill, M.D.;
March 20, 1942, *Psychopathological Disorders in Childhood*—William S. Langford, M.D.;
March 27, 1942, *Cancer of the Cervix and Fundus Uteri*, Panel Discussion—George Gray Ward, M.D., Chairman;
April 10, 1942, *Edema: Its Pathogenesis and Treatment*—William Goldring, M.D.;
April 17, 1942, *Neuropsychiatric Aspects of Alcoholism*—Herman Wortis, M.D.;
April 24, 1942, *Rehabilitation Surgery*—Henry H. Kessler, M.D.

Philadelphia County Medical Society
21st & Spruce Sts.
Philadelphia, Pa.

The 7th Annual Postgraduate Institute of the Philadelphia County Medical Society will be held in Philadelphia, April 13–17, 1942, under the direction of Dr. Rufus S. Reeves. The subject of this Institute will be "Modern Therapy" and will cover Arthritis, Blood Dyscrasias, Chemotherapy, Diabetes, Industrial Medicine, Nutrition, Ophthalmology, Tuberculosis and Proctology. Members of the Society are admitted without fee; others, $5.00.

Tennessee State Medical Association
706 Church St.
Nashville, Tenn.

During 1941–42 the Tennessee State Medical Association will sponsor a series of postgraduate courses in the various branches of medicine and surgery. An outstanding instructor is selected to present in various centers throughout the state one lecture per week for a period of ten weeks. Teaching centers are established where a sufficient number of physicians are interested and the hours, day and dates arranged to suit the group in each district.

Dr. Robert P. McCombs will be the instructor of the postgraduate course in internal medicine. The subjects of his lectures will be: *Disorders of the Heart; Cardiovascular-Renal Disease; The Management of Heart Failure and Renal Failure; Nutritional Diseases; The Anemias and Blood Dyscrasias; Diabetes Mellitus; Chronic Non-Tuberculous Pulmonary Diseases; The Uses and Abuses of Sulfanilamide, Sulfapyridine and Sulfathiazole in the Practice of Medicine; Gastrointestinal Diseases;* and *Chronic Arthritis.*

Wayne County Medical Society
4421 Woodward Ave.
Detroit, Mich.

The Continuation School of Wayne County, sponsored by the Wayne County Medical Society in coöperation with Wayne University College of Medicine, the hospitals of Wayne County and the Detroit Department of Health, offers a series of part-time postgraduate courses throughout the year in the various medical and surgical specialties. During 1941–42 the following courses will be offered:

ALLERGY

9. *Bedside Teaching in Diagnosis and Treatment of Allergic Conditions*—William J. Seymour Hospital, Eloise.
10:00 a.m. to 12:00 m., Tuesdays; weekly throughout the year; Fee, $5.00.
23. *Clinical Allergy*—Mt. Carmel Mercy Hospital, Detroit.
11:00 a.m. to 12:00 m., Tuesdays; specific dates not announced; Fee, $5.00.

DERMATOLOGY

16. *Dermatology*—The Grace Hospital, Detroit.
11:00 a.m. to 12:00 m., Saturdays; specific dates not announced; Fee, $5.00.

DIABETES

6. *Bedside Teaching in General Medicine, with Particular Reference to Diabetes*—William J. Seymour Hospital, Eloise.
10:00 a.m. to 12:00 m., Saturdays; weekly throughout the year; Fee, $5.00.
11. *Management of Diabetes*—The Grace Hospital, Detroit.
11:00 a.m. to 12:00 m., Wednesdays; specific dates not announced; Fee, $5.00.

GASTRO-ENTEROLOGY

13. *Gastro-enterology*—The Grace Hospital, Detroit.
11:00 a.m. to 12:00 m., Thursdays; specific dates not announced; Fee, $5.00.

GENERAL MEDICINE

5. *Bedside Teaching in General Medicine*—William J. Seymour Hospital, Eloise.
11:00 a.m. to 12:00 m., Mondays; weekly throughout the year; Fee, $5.00.
7. *Bedside Teaching in General Medicine*—William J. Seymour Hospital, Eloise.
11:00 a.m. to 12:00 m., Wednesdays; weekly throughout the year; Fee, $5.00.
10. *General Medicine and Clinical Diagnosis*—The Grace Hospital, Detroit.
11:00 a.m. to 12:00 m., Tuesdays; specific dates not announced; Fee, $5.00.
12. *Non-Tuberculous Diseases of the Chest*—The Grace Hospital, Detroit.
11:00 a.m. to 12:00 m., Thursdays; specific dates not announced; Fee, $5.00.
18. *Bedside Teaching in General Medicine*—Harper Hospital, Detroit.
Two months; 11:00 a.m. to 12:00 m., Mondays and Thursdays, during March and April, 1942; Fee, $5.00.
22. *General Medicine*—Highland Park General Hospital, Highland Park.
9:00 to 10:00 a.m., Fridays; specific dates not announced; Fee, $5.00.

NEUROLOGY

8. *Bedside Teaching in Neurology*—William J. Seymour Hospital, Eloise.
11:00 a.m. to 12:00 m., Wednesdays; weekly throughout the year; Fee, $5.00.
19. *Neurology and Neuropsychiatry*—Harper Hospital, Detroit.
Eight weeks; 11:00 a.m. to 12:00 m., Tuesdays, during December, 1941, and January, 1942; Fee, $5.00.

PEDIATRICS

21. *Pediatrics*—Henry Ford Hospital, Detroit.
9:15 to 10:30 a.m., Tuesdays; specific dates not announced; Fee, $5.00.

PHYSIOTHERAPY

14. *Physiotherapy*—The Grace Hospital, Detroit.
10:00 a.m. to 12:00 m., Wednesdays; specific dates not announced; Fee, $5.00.

SYPHILOLOGY

15. *Syphilology*—The Grace Hospital, Detroit.
11:00 a.m. to 12:00 m., Thursdays; specific dates not announced; Fee, $5.00.
26. *Syphilology*—Receiving Hospital, Detroit.
10:00 to 11:00 a.m., Fridays; specific dates not announced; Fee, $5.00.

School of Tropical Medicine
University of Puerto Rico
San Juan, Puerto Rico.

Starting November 5, 1941 and ending January 21, 1942, a series of lectures on Tropical Medicine will be presented at the School of Tropical Medicine, San Juan, Puerto Rico, by various members of the department of Medicine. The following subjects are to be discussed: Lymphogranuloma inguinale; sprue; pellagra, ariboflavinosis and other deficiency diseases, Weil's disease, yaws, rat-bite fever, typhoid fever, paratyphoid A and B; amebic dysentery, tropical lymphangitis, clinical aspects of intestinal parasites, malarial fevers and blackwater fever, and schistosomiasis mansoni.

The lectures will be given by Dr. Ramón M. Suárez, F.A.C.P., head of the Department of Medicine of the School, by Dr. R. Rodríguez-Molina, F.A.C.P., and by Dr. F. Hernández Morales.

MINUTES OF THE BOARD OF GOVERNORS

Boston, Mass.

April 21, 1941

The first meeting of the Board of Governors, in conjunction with the Twenty-fifth Annual Session of the American College of Physicians, convened in the Hancock Room, Hotel Statler, Boston, Mass., Monday, April 21, 1941, at 5:15 p.m., with Dr. Charles H. Cocke, Chairman, presiding, and the following in attendance:

Dr. James F. Churchill, Dr. James J. Waring, Dr. Charles H. Turkington, Dr. Wallace M. Yater, Dr. Cecil M. Jack (representing Dr. Samuel E. Munson), Dr. Robert M. Moore, Dr. Thomas Tallman Holt, Dr. William B. Breed, Dr. Warren Thompson, Dr. Nelson G. Russell, Dr. Leander A. Riely, Dr. Edward L. Bortz, Dr. John L. Calene, Dr. J. Owsley Manier, Dr. Tomas Guardia Guardia (representing Dr. William M. James), Dr. J. Howard Holbrook, Dr. Oliver C. Melson, Dr. Ernest H. Falconer, Dr. Benjamin F. Wolverton (representing Dr. Fred M. Smith), Dr. W. S. Kerlin (representing Dr. Joseph E. Knighton), Dr. Henry R. Carstens, Dr. Edgar V. Allen, Dr. A. Comingo Griffith, Dr. George H. Lathrope, Dr. Charles H. Cocke, Dr. Julius O. Arnson, Dr. Alexander M. Burgess, Dr. Paul K. French, Dr. Walter B. Martin, Dr. Charles E. Watts, Dr. Hugh A. Farris, Dr. Charles F. Moffatt, Dr. Fred W. Wilkerson, Dr. Lewis B. Flinn, Dr. Turner Z. Cason, Dr. Ernest B. Bradley (representing Dr. C. W. Dowden), Dr. Eugene H. Drake, Dr. Louis Krause, Dr. John G. Archer, Dr. Charles F. Tenney, Dr. A. B. Brower, Dr. Homer P. Rush, Dr. M. D. Levy, Dr. Karl H. Doege (representing Dr. Elmer L. Sevringhaus), Dr. George F. Strong and Dr. John M. McCants (representing Dr. Ross T. McIntire).

The Secretary, Mr. E. R. Loveland, read abstracted Minutes of the preceding meetings held at Cleveland, 1940, which were approved as read.

Chairman Cocke introduced President James D. Bruce, who addressed the Board primarily on the subject of continuing education and the work of the American College of Physicians in connection with its postgraduate program.

The Executive Secretary made a full report to the Board on the College membership during the preceding year, including deaths, life membership, elections to Associateship and Fellowship, and similar matters. He also distributed a copy of the 1941 Balance Sheet and other financial data for the information of the Board. Each Governor was given a mimeographed list of the candidates recommended for election at the current meeting by the Committee on Credentials.

Chairman Cocke announced to the Board the election to Mastership of former President James Alex. Miller. He also announced the election to Fellowship in the College of a group of prominent Cuban physicians, and announced that until further regulations are adopted, Cuba would be included in the territory for which the Governor of Florida is responsible.

Dr. Turner Z. Cason, Governor for Florida, stated that he had been interested for several years in bringing into the College a number of men from Cuba, particularly from the University of Havana, and that after the group had been carefully organized and investigated, they had been invited to attend the Florida Regional Meeting of 1940, when the Florida contingent had met them all personally and discussed their type of practice. At this Regional Meeting the Chairman of the Board of Governors, Dr. Cocke, and the Executive Secretary of the College, Mr. Loveland, were guests and presented addresses concerning the College activities, aims and standards. Dr. Cason assured the Board that the new Cuban members were men of the highest type who will do honor to the College, and that other candidates from

Cuba will be carefully examined and investigated, and the high standards maintained. He felt that nothing that has been done recently should encourage better relations between Cuba and the United States than the election of these outstanding Cuban physicians. Many of these men have in the past gone to Europe for graduate study, and their election and association with the College will undoubtedly have a force in the future to divert more Cuban physicians to this country for their graduate training. Dr. Cason further stated that these new members will attend the College meetings and take an active part.

Chairman Cocke reported the following transactions of the Board of Regents of December 15, 1940: Adoption of the following resolution:

"*Resolved*, that the Board of Regents shall compliment the Board of Governors for what has already been accomplished and urge the further expansion of the program of regional meetings; that the Executive Office shall be authorized to meet incidental expenses in connection with such meetings and also to give an allowance for traveling expenses of Officers of the College who are asked to attend these meetings."

In support of this resolution, the Regents had made an appropriation of $500.00 for 1941.

Continuing, Chairman Cocke said: "As Dr. Bruce has told you, the whole emphasis of this meeting is postgraduate education; the advantages of the College, and what it has to offer are still unknown to a great many men who are members of this College. Cultivation of the Regional Meetings is one of the best ways in which the men can be accorded the contact with the activities of the College, learn something of the advantages the College offers.

"I hope as you develop these things that these Regional Meetings will grow, because that is one of the primary functions of the College. You can do no better service to your men than by the organization of these meetings to encourage them to come to the courses and the College meetings generally."

At this point, Chairman Cocke called upon Dr. Edward L. Bortz, Chairman of the Advisory Committee on Postgraduate Courses, for a report.

Dr. Bortz: "Mr. Chairman, President Bruce and Governors. When President Bruce appointed this Committee a year ago, as you know, the Committee was made up of the Dean of Harvard Medical School, Sidney Burwell, Fred Smith of Iowa, Ernest Falconer of California, James J. Waring of Colorado, and myself as Chairman.

"We were fortunate in having the leadership of Dr. Bruce in this important matter. Dr. Bruce, as you know, has been a leader in postgraduate and graduate medical education for a great many years in this country, and it was due to his inspiring understanding and energy that the State of Michigan has taken the lead in graduate medical education in this country. It was a fortunate thing when the College honored itself in appointing him to be its President, and our Committee came along just at the time that he assumed the Presidential office.

"At this time, I want to pay tribute to the energy and enthusiasm of the members of the Committee who have worked so hard in furthering the work.

"Now, in order to find out exactly what the extent of interest was in the field of graduate medical education on the part of the members, it was necessary to send out a questionnaire and have a great many conferences and a lot of correspondence with the officials of the College and the various members to find out just what they would like to have in the way of postgraduate courses for the current year.

"Of the 4,000 questionnaires sent out, we had a return of almost 1,000, which, in our opinion, is a very excellent return.

"Of the 918 or 920 questionnaires that were returned, more than half of those men signified the desire to take a course of some sort in one of these postgraduate courses, such as cardiology, gastro-enterology, hematology, allergy or neurology.

"The Committee organized ten courses, and made a recommendation to the Board of Regents that these courses be given.

"This Committee is a fact-finding Committee and is not an executive committee; it has no power of its own to carry on any courses; it studies the situation and makes proper recommendations to the Executive Committee of the College and to the Board of Regents, and that is the body under the President which finally acts and okays and activates the whole movement, as it were.

"In passing, I want to say to you that this work could not have been consummated and the whole program would not have been possible had it not been for the unfailing coöperation and wise, helpful guidance that the Committee has received from Mr. Loveland, who worked day and night with the Committee, and when we got off the wise course many times, he got us back on the right course, so that I feel very grateful to Mr. Loveland for the help he gave us.

"Now, we found out that a good many of the men wanted to take courses, not only just before the Annual Session, but they wanted to have courses at other times of the year. Therefore, a recommendation was made that the Board of Regents, the Executive Committee, establish some courses to be given in February. We were so late in getting out the information and the publicity on it; but, even so, the courses that were given, with the exception of one course in Allergy, were outstandingly successful.

"It was my good privilege to have attended the course at the Mayo Clinic, the first course ever given at the Mayo Clinic under the auspices of the College. Dr. Allen organized a course there and this was attended by thirty-five men. I had the opportunity of talking to practically all of them, and then Dr. Cocke talked with the Director of the Mayo Foundation. He told us: 'I am free to say to you that in all the experience of the Mayo Clinic, we have never had a group of men so enthusiastic, so well trained, so ready for advanced instruction in medicine as this group that has been sent to us by the American College of Physicians. From now on, we want to coöperate with you in every way we possibly can.'

"The men who attended that course and the other courses were very enthusiastic about the instruction that they received. These men aren't going to these courses for the purpose of getting what the men used to go to Vienna for, a diploma to put up on the wall and prove that they were specialists; they don't care about that. They are interested in qualifying themselves to be better internists.

"We think this movement is the finest thing of its kind that the American College of Physicians has undertaken, and it is one of the great responsibilities that the College has to carry on, now, and in the future.

"The Committee believes that certain courses should be given next year, as follows:

Two Courses in General Medicine—of two weeks' duration;
Two Courses in Cardiovascular Disease—of two weeks' duration;
Two Courses in Gastrointestinal Disease—one of two weeks' duration and one of one week's duration;
One Course in Hematology, or Arthritis and Rheumatism—of one week's duration;
One Course in Tuberculosis—of one week's duration.

"We believe these courses should be organized as soon as possible, after the Board of Regents has decided where the Annual Session is going to meet next year, and then if the Board of Regents authorizes the Committee to go ahead, and provided it is the same Committee, this Committee is only appointed from year to year, it will make proper contacts and have the courses arranged so that the adequate publicity can be given to these courses early in the summer.

"With that in mind, men will have sufficient time to decide what courses they want to attend, and also the men who give the courses will have an adequate opportunity to organize the personnel of the institutions which are selected.

"I want to thank the Board of Governors who were so gracious in sending comments and criticisms. It has been an inspiration to me and every one on the Committee to participate in this great and significant movement in medical education in the United States."

Chairman Cocke then called upon Dr. Edgar V. Allen, of Rochester, Minn., for a report.

DR. ALLEN: "Chairman Cocke, President Bruce and Governors. This is our first experience in Rochester in having a course in postgraduate medical education. I can say very honestly that I am sure those who participated in the course enjoyed it more than those who were subjected to the course. The men who came, thirty-five in number, were subjected to eight hours a day for two weeks, and that is quite a bit. They are always alert, interested, ask many questions and in many instances ask questions which go to the very advanced information about the field in which we were giving the courses of advanced instruction.

"I can speak for our organization in saying that it was a pleasure for us to have this group and that we hope in the future we shall be called upon again, and if, by any chance, we are, we shall try to do it at least as well as we did in February, and, of course, we shall try to do it better."

Chairman Cocke then asked for questions from the Governors on the subject. Dr. Robert M. Moore, Governor for Indiana, described the intensive postgraduate course organized and given by the Indiana State Medical Association, and inquired if this course might also be listed as available for the College group. He said there is a definite course in Internal Medicine, and suggested the possibility that since the University Hospital and the University have all the machinery and adequate material available some course for the College might be given there. Chairman Cocke stated that the suggestion would be taken under consideration by the College Committee.

At this point, Chairman Cocke read a number of items from the Minutes of the Board of Regents of December 15, 1940, for the enlightenment of the Board of Governors, concerning regulations for the admission of non-members to postgraduate courses, the limitation of the volume of the 'Annals' to 2,400 pages per annum, the membership of the American College of Physicians on the National Research Council and the appropriation by the College of funds for the support of research in the National Research Council, including an appropriation for classification of internists in the office of Dr. James E. Paullin. Chairman Cocke also read a resolution of the Board of Regents regarding the appointment of a Committee to investigate the feasibility of establishing courses of instruction in Internal Medicine for the personnel of General Hospitals to be established by the Army; also a resolution providing $1,800.00 to cover reprinting of the College History for an adequate supply for future Fellows and Associates of the College.

At this point, Chairman Cocke asked for reports of Regional Meetings that had been held by various Governors.

Dr. Ernest H. Falconer, Governor for Northern California, reported a College Regional Meeting at San Francisco at the time of the Pacific Coast Interurban Society's meeting. Having the meeting at the same time as the Interurban Society was planned so that there would be increased attendance, for many College members belong to both organizations. About forty members were in attendance, as were also Governor Watts of Washington and Dr. S. Marx White of Minneapolis and Governor Strong of Vancouver. Dr. Falconer stated that many members of the College had very little conception of what this organization is doing in the way of postgraduate education. Some thought that the College was trying to educate the general practitioner. The

meeting stimulated a desire to attend more of the College Sessions and some of the Postgraduate Courses. Following the meeting, several members sent in suggestions for the coming years. Dr. Falconer expressed the opinion that the meeting had done a great deal of good and that a larger number of members would participate in the future.

Dr. R. R. Snowden, Governor for Western Pennsylvania, reported on a Regional Meeting held in Pittsburgh, and expressed both surprise and gratification with the ease with which the members were influenced to attend. As it was, about 90 per cent of the members in Western Pennsylvania were present. The meeting was addressed by Dr. George Morris Piersol, Secretary-General of the College, Dr. Edward L. Bortz, Governor for Eastern Pennsylvania, and Chairman of the Advisory Committee on Postgraduate Courses, and by Mr. E. R. Loveland, Executive Secretary of the College. Dr. Piersol's address had dealt with the standards and requirements for admission, and proved exceedingly valuable in educating the members to a better understanding of what the College means and in particular of its high standards of admission. Dr. Snowden especially recommended the feasibility of holding regional meetings in every Governor's district.

Dr. Ernest B. Bradley, former President and also former Governor for Kentucky, at this time serving as Alternate for Dr. C. W. Dowden, who was absent because of illness, made a brief address.

Dr. Charles F. Tenney, Governor for Eastern New York, reported upon a Regional Meeting held in New York City just two weeks previous, at which there was a program of clinics and panels in the morning, exhibits in the afternoon and lectures in the evening. This meeting actually was the Postgraduate Fortnight of the New York Academy of Medicine, but Governor Tenney had made it a practice to bring the meeting to the attention of members of the College in Eastern New York.

Again Dr. Robert M. Moore, Governor for Indiana, brought up the matter of the possibility of combining a portion of the postgraduate program of the Indiana State Medical Association at Indianapolis with a continuation of postgraduate work for members of the College, while the organization machinery is all set up.

President Bruce questioned the propriety of an attempted integration on one level; that is, of postgraduate education for the practitioner and postgraduate education for men in the specialties. Dr. Bruce referred to the North Carolina meeting of the College which he had attended. He referred to the presentations as being of the highest calibre, saying the speakers might well have been gracing positions in the best of medical schools in this country, and a few of them were, but the majority were men out of actual practice. Dr. Bruce had been impressed with the opportunity there is for members of the College to assume leadership in medical education in their communities, not only in postgraduate work of the College itself, but in the continuing education of the practitioner.

At the request of Governor Tenney, Dr. Edward L. Bortz reported on the Regional Meeting in Eastern Pennsylvania, held at Philadelphia in February. Dr. Bortz expressed the opinion that every member of the College has an obligation and a responsibility because of his membership; that he ought to contribute something to the College, even if it is nothing other than his presence at one of the meetings. Out of a total membership of approximately 250 in Eastern Pennsylvania, more than 200 had attended the Regional Meeting. Obviously the number of members is too large for the Governor to personally contact them, and, therefore, Dr. Bortz had appointed a so-called Governors' Committee of about fifteen members, asking each of them to contact a certain group of members and seeing that they would be in attendance. A luncheon was held at the College Headquarters, followed by an afternoon scientific session at Jefferson Medical College and the evening by a cocktail hour and dinner at the Penn Athletic Club, with some special addresses.

These Eastern Pennsylvania Regional Meetings, said Dr. Bortz, are looked upon by the members as the most enjoyable medical meetings of their type anywhere, and the members are looking forward already to the one in the coming year. These meetings are extending the influence and the interest in the College in Eastern Pennsylvania; they are telling younger men about the work of the College; they are becoming interested to become members. The American College of Physicians has a beneficient influence on the whole group of doctors throughout Eastern Pennsylvania. At the Eastern Pennsylvania meeting, Dr. Bortz had invited the Governors of the surrounding States. Governor Tenney, of Eastern New York, and Governor Flinn, of Delaware, and Governor Burgess, of Rhode Island, were in attendance.

Governor Flinn, of Delaware, spoke further about the Eastern Pennsylvania meeting; not only had he been invited to attend, but also all of the College members in the State of Delaware. Ninety-five per cent were in attendance, and the enthusiasm locally in Delaware resulting therefrom had been greatly increased.

Dr. Nelson G. Russell, Governor for Western New York, stated that in lieu of a regular Regional Meeting of that district, College members had been invited to the clinical meeting of the Alumni of the University of Buffalo. Eighty members accepted the invitation, thirty-five of whom remained for the dinner in the evening. An exceptionally good program was provided.

Dr. Edgar V. Allen, Governor for Minnesota, stated that he wished to make it a matter of record that two of the best presentations given in connection with the College Postgraduate Course at the Mayo Clinic were those of Dr. Cocke, Chairman of the Board of Governors, and of Dr. Bortz, Chairman of the Advisory Committee on Postgraduate Education.

After announcements by the Chairman, the meeting adjourned at 6:20 p.m.

Attest: _____

Executive Secretary

MINUTES OF THE BOARD OF GOVERNORS

BOSTON, MASS.

April 23, 1941

The second meeting of the Board of Governors, in conjunction with the Twenty-fifth Annual Session of the American College of Physicians, convened in the Hancock Room, Hotel Statler, Boston, Mass., Wednesday, April 23, 1941, at 12:30 p.m., with Dr. Charles H. Cocke, Chairman, presiding, and the following in attendance:

Dr. James F. Churchill, Dr. James J. Waring, Dr. Charles H. Turkington, Dr. Wallace M. Yater, Dr. Samuel E. Munson, Dr. Robert M. Moore, Dr. William B. Breed, Dr. Warren Thompson, Dr. Nelson G. Russell, Dr. Leander A. Riely, Dr. Edward L. Bortz, Dr. R. R. Snowden, Dr. John L. Calene, Dr. J. Owsley Manier, Dr. Louis E. Viko, Dr. J. Howard Holbrook, Dr. Oliver C. Melson, Dr. Ernest H. Falconer, Dr. Benjamin Wolverton (representing Dr. Fred M. Smith), Dr. W. S. Kerlin (representing Dr. Joseph E. Knighton), Dr. Henry R. Carstens, Dr. Edgar V. Allen, Dr. A. Comingo Griffith, Dr. George H. Lathrope, Dr. Charles H. Cocke, Dr. Julius O. Arnson, Dr. Alexander M. Burgess, Dr. Robert Wilson (representing Dr. Kenneth M. Lynch), Dr. Paul K. French, Dr. Walter B. Martin, Dr. Charles E. Watts, Dr. Walter E. Vest (representing Dr. Albert H. Hoge), Dr. Hugh A. Farris, Dr. Charles F. Moffatt, Dr. Fred W. Wilkerson, Dr. Turner Z. Cason, Dr. LeRoy H. Sloan, Dr. Ernest B. Bradley (representing Dr. C. W. Dowden), Dr. Eugene H. Drake, Dr. Louis Krause, Dr. John G. Archer, Dr. Charles F. Tenney, Dr. A. B. Brower, Dr. Homer P. Rush, Dr. M. D. Levy, Dr. Karl H. Doege (representing Dr.

Elmer L. Sevringhaus), Dr. George F. Strong, Dr. John M. McCants (representing Dr. Ross T. McIntire) and Dr. Thomas Parran.

Secretary Loveland read a resume of the minutes of the preceding meeting of April 21, which were approved as read.

Chairman Cocke proceeded to new business, first being the election of a Chairman and Vice Chairman. He read the By-Laws, Article VI, Section 3, governing the election of the Chairman and Vice Chairman of the Board of Governors.

On motion by Dr. A. Comingo Griffith, seconded by Dr. Oliver C. Melson, Dr. Charles H. Cocke was renominated as Chairman of the Board of Governors for a term of three years. Nominations by resolution were closed, and the Secretary was instructed to cast the ballot for the election of Dr. Cocke.

On motion by Dr. Alexander M. Burgess, seconded by Dr. Charles E. Watts, Dr. C. W. Dowden was renominated as Vice Chairman for a term of three years. On motion regularly adopted, nominations were closed and the Secretary instructed to cast a ballot for the election of Dr. Dowden as Vice Chairman.

Accordingly, the Secretary declared the ballot cast and both Dr. Cocke and Dr. Dowden reëlected to the Chairmanship and Vice Chairmanship, respectively.

Chairman Cocke reported the proceedings of the Board of Regents, referring especially to resolutions that had been adopted. The Board of Regents commended the activity of the Advisory Committee on Postgraduate Courses and directed that there should be a continuity of effort of the Committee, with the suggestion that the present Committee be reappointed, not necessarily as it is now constituted, but with adequate continuity so that the work could go on without interruption.

Thereupon Dr. Cocke announced the personnel of the Committee for 1941–42 to be composed of:

Edward L. Bortz, *Chairman*
Ernest H. Falconer
Fred M. Smith
James J. Waring
C. Sidney Burwell

all being reappointed.

Dr. Nelson G. Russell interrupted the proceedings to refer to the complimentary concert of the Boston Symphony Orchestra, saying it was the most inspiring affair that he had had the pleasure to attend in all of his years of going to medical meetings, and expressed the opinion that the Board of Governors should express its appreciation to the Conductor of the Orchestra and to the Committee and Dr. Roger I. Lee, who was responsible for the original arrangements. He asked that a note of appreciation be recorded and forwarded to the Orchestra through the proper channels.

The audience arose and there was long applause accorded to Dr. Lee, who graciously acknowledged the ovation.

At this point Dr. Lee addressed the Board.

Dr. Lee explained how the Trustees of the Boston Symphony Orchestra and the Conductor, Dr. Koussevitzky, had gladly agreed to give the Concert for the College, and if the members of the College had liked the Concert all of those locally responsible were very happy. Continuing he said:

"I have nothing to say as the President-Elect. The President-Elect is like the fifth wheel on a spare tire on the automobile. Usually, when you want it, you find that it suffers the same reverses as the other four. Sometimes it isn't even inflated Whatever inflation that I may personally enjoy is the inflation of my constitution, and I hope that the inflation of the job which I am going to undertake will not be any more obvious than it is now. (Laughter.)

"I have always been very much interested in the work of the Board of Governors. I sat on the Board of Governors for a few years, and it has seemed to me that it has been on the whole a very wise policy of the College of Physicians that in these formative years, a good deal of the power and authority was concentrated in the Regents. As time goes on, there will be more power in the Board of Governors, and I think that is being done at the present time. It is certainly my intention, as far as my feeble powers will permit me, to continue that very definite trend. Eventually, of course, as it becomes standardized, it will be necessary that in a democratic institution, the activities, authority and powers that now rest largely in the Regents will be turned over somewhat to the Board of Governors, to the membership-at-large. That, of course, is a necessity in a democratic organization. However, at the present time, the concentration which still seems to me to be over-emphasized in the Board of Regents has to be gradually turned over to a certain extent to this body of Governors, and they, in turn, will turn it over to the membership-at-large.

"It is my general notion as to the function of the Governors as a body and individually, that individually and collectively they will have a much greater share in determining the activities and the policies of the College than they have had in the past. That seems to me definitely in order and it is taking place, and I shall do my best to give it a further push." (Applause.)

Chairman Cocke then announced the appointment of one member of the Credentials Committee, whose term of service then expired. He reappointed Dr. J. Owsley Manier, Nashville, Tenn.

Dr. Cocke then introduced Dr. Thomas Parran, College Governor and Surgeon General of the United States Public Health Service. (Dr. Parran's remarks at his request were omitted from these records.)

Chairman Cocke asked if there was any general business to bring before the meeting.

Dr. Eugene H. Drake, Governor for Maine, inquired if there were any special arrangements for Associates called to active military service, such as the extension of their Associate term beyond the five-year period prescribed in the By-Laws.

Chairman Cocke remarked that the matter was under consideration by the Board of Regents, and he felt assured that proper and adequate provision would be made for such men in some manner.

Dr. William B. Breed, as General Chairman, addressed the Board, pointing out that the Governors have a definite responsibility to the physicians who have been elected to Fellowship, and that the Board ought to urge as many as possible from their individual districts to be present at the Convocation, Wednesday evening. He also urged the Governors to attend the Banquet, and to aid the management by urging other physicians to obtain their tickets early.

Chairman Cocke brought up the matter of the meeting place for 1942, stating that while the Board of Regents have power for decision, the Board of Governors nevertheless is expected to make some sort of expression of preference. He asked the Executive Secretary to announce the cities from which invitations had come and the representatives from those cities to discuss their facilities. The Secretary announced the list of cities in alphabetical order, as follows: Buffalo, Milwaukee, Indianapolis, Kansas City, St. Paul and San Francisco. He discussed the supporting invitations from the local County Medical Societies, the State Medical Societies, the Universities, civic bodies, etc.

Dr. Nelson G. Russell, on behalf of Buffalo, stated that they would be very happy to entertain the College, but had hesitated somewhat on account of limited facilities. He said, however, that he felt that Buffalo could furnish the proper number of clinics and hospital programs, and that the Buffalo Academy of Medicine and the University of Buffalo would join in the invitation.

Dr. Karl H. Doege, Alternate Governor for Wisconsin, stated that he knew nothing of the Milwaukee invitation, but expressed the opinion that housing facilities were adequate, but that distances to hospitals were rather long.

Dr. Robert M. Moore, Governor for Indiana, expressed the belief that Indianapolis would soon be ready for a College meeting, and he hoped that an invitation would be accepted in the not distant future.

Dr. A. Comingo Griffith, Governor for Missouri, talked at greater length about the Kansas City invitation, extending the cordiality of the invitation and expressing his confidence that Kansas City would handle the meeting in a thoroughly successful manner.

Dr. Edgar V. Allen, Governor for Minnesota, spoke on behalf of the St. Paul invitation. On behalf of the Governor of the State, the Mayor of St. Paul and the entire medical profession of the State, he extended a very cordial invitation to meet in St. Paul in 1942. On inquiry from one of the members, Dr. Allen explained that the Mayo Clinic is too far removed from St. Paul for participation in the meeting. He said the meeting could best be handled in St. Paul and Minneapolis.

Dr. Ernest H. Falconer spoke in regard to the invitation from San Francisco. He expressed the desire to have the College return, but emphasized the importance of picking a year when there would be no disturbing influences to keep the members away, especially those from the eastern part of the country.

Dr. Cocke pointed out that the matter of physical facilities, opportunities for clinics, hospital programs, hotel accommodations, meeting halls and other considerations must be studied before an ultimate decision can be made by the Regents, regardless of suggestions or recommendations that may be made by the Governors.

By motion regularly made, seconded and carried, it was agreed that the invitations from Kansas City and St. Paul be considered by popular vote.

Chairman Cocke asked for a showing of hands. There were nineteen votes for St. Paul and twenty votes for Kansas City, which Dr. Cocke stated he would report to the Board of Regents.

On motion by Dr. A. Comingo Griffith, seconded by several and unanimously carried, it was

Resolved, that the Board of Governors extend to those members of the College who had worked so hard on the preparation of the Boston meeting a cordial vote of thanks.

After announcements by Dr. Cocke, the meeting adjourned at 1:40 p.m.

Adjournment

Attest:———————————

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